MEDPAC'S JUNE 2010 REPORT TO CONGRESS: ALIGNING INCENTIVES IN MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

JUNE 23, 2010

Serial No. 111–139

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

77–916 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

HENRY A. WAXMAN, California, *Chairman*

JOHN D. DINGELL, Michigan
Chairman Emeritus
EDWARD J. MARKEY, Massachusetts
RICK BOUCHER, Virginia
FRANK PALLONE, JR., New Jersey
BART GORDON, Tennessee
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
Vice Chairman
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANE HARMAN, California
TOM ALLEN, Maine
JANICE D. SCHAKOWSKY, Illinois
CHARLES A. GONZALEZ, Texas
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
CHARLIE MELANCON, Louisiana
JOHN BARROW, Georgia
BARON P. HILL, Indiana
DORIS O. MATSUI, California
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
CHRISTOPHER S. MURPHY, Connecticut
ZACHARY T. SPACE, Ohio
JERRY MCNERNEY, California
BETTY SUTTON, Ohio
BRUCE L. BRALEY, Iowa
PETER WELCH, Vermont

JOE BARTON, Texas
Ranking Member
RALPH M. HALL, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
NATHAN DEAL, Georgia
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOHN B. SHADEGG, Arizona
ROY BLUNT, Missouri
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
JOSEPH R. PITTS, Pennsylvania
MARY BONO MACK, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
PHIL GINGREY, Georgia
STEVE SCALISE, Louisiana

SUBCOMMITTEE ON HEALTH

FRANK PALLONE, JR., New Jersey, *Chairman*

JOHN D. DINGELL, Michigan
BART GORDON, Tennessee
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
JANICE D. SCHAKOWSKY, Illinois
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
JANE HARMAN, California
CHARLES A. GONZALEZ, Texas
JOHN BARROW, Georgia
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
CHRISTOPHER S. MURPHY, Connecticut
ZACHARY T. SPACE, Ohio
BETTY SUTTON, Ohio
BRUCE L. BRALEY, Iowa

NATHAN DEAL, Georgia,
Ranking Member
RALPH M. HALL, Texas
BARBARA CUBIN, Wyoming
JOHN B. SHADEGG, Arizona
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
MARY BONO MACK, California
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas

CONTENTS

MEDPAC'S JUNE 2010 REPORT TO CONGRESS: ALIGNING INCENTIVES IN MEDICARE

WEDNESDAY, JUNE 23, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:04 p.m. , in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Eshoo, Engel, Green, Schakowsky, Baldwin, Weiner, Barrow, Christensen, Castor, Space, Sutton, Waxman (ex officio), Shimkus, Whitfield, Myrick, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey and Barton (ex officio).

Staff Present: Phil Barnett, Staff Director; Karen Nelson, Deputy Committee Staff Director for Health; Katie Campbell, Professional Staff Member; Stephen Cha, Professional Staff Member; Tim Gronniger, Professional Staff Member; Virgil Miller, Professional Staff Member; Anne Morris, Professional Staff Member; Allison Corr, Special Assistant; Karen Lightfoot, Communications Director, Senior Policy Advisor; Elizabeth Letter, Special Assistant; Lindsay Vidal, Special Assistant; Mitchell Smiley, Special Assistant; Emily Gibbons, Professional Staff Member; Clay Alspach, Minority Counsel, Health; Marie Fishpaw, Minority Professional Staff, Health; Sean Hayes, Minority Counsel; and Ryan Long, Minority Chief Counsel, Health.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The subcommittee hearing will come to order. Today the Health Subcommittee is meeting to hear about the Medicare Payment Advisory Commission's, or MedPAC, June 2010 report on aligning incentives in Medicare. And let me begin by welcoming to the subcommittee Mr. Glenn Hackbarth, who currently serves as Chairman of the Commission and will be our only witness testifying before us today. So thank you for being here.

I am going to recognize myself for an opening statement initially. Every year MedPAC is required under the law to issue two reports and advise Congress on issues affecting the Medicare program. I believe that the report we are discussing today holds particular significance because it is the first report issued by MedPAC since passage of the new health reform law.

I think that is significant for a couple of reasons. First, the contents of this report demonstrate the need for some of the policies that were included in the new health reform law, including provisions that will improve the quality of care and strengthen the financial sustainability of Medicare.

Take, for example, the first chapter of this year's report, which examines opportunities to enhance Medicare's ability to innovate. The report notes that the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services need greater flexibility to implement innovative payment, coverage and delivery system reform policies in Medicare. As the Commission's report currently points out, as part of the Patient Protection and Affordable Care Act, Congress authorized the creation of a Center for Medicare and Medicaid Innovation within CMS. In addition, the new health reform law improves the flexibility that HHS and CMS have over Medicare by—and I will give you some examples first—simplifying the demonstration approval and implementation process within CMS; second, authorizing new funding for CMS to carry out important new demonstrations that will improve quality and lower health care costs; and third, creating a new process by which the Secretary of HHS can expand successful demonstrations without further congressional approval.

Now, on that last note, while I agree the agency needs further flexibility to test new models and improve Medicare's health delivery system, I am not in favor of giving carte blanche to the Secretary of HHS or the CMS Administrator. I believe that this committee and the members who serve on it carry out an important oversight and regulatory role, and I am not eager to hand over all of our responsibilities to effectively manage this program to our friends at HHS.

This year's report also talks about the need for better care coordination, especially among some of Medicare's most vulnerable patients, such as those that are dually eligible for both Medicare and Medicaid. The new health reform law also makes inroads in this area with the inclusion of new team-based and integrated care models for delivery of health care services such as accountable care organizations, medical homes and bundled payments.

It is clear to me that there is a lot of correlation between some of the recommendations made in this month's report and some of the initiatives that were included in the new health reform. But the Commission's new report also seeks to examine other opportunities for the Congress to improve the Medicare program. For example, the Commission takes a fresh look at the way Medicare funds graduate medical education in the country and makes recommendations on how to improve it. The Commission also looks at the growth of payments for in-office ancillary services, an issue that they have examined in the past. However this year, instead of simply looking at how physician behavior is adding to the growth of these services, MedPAC also looks at the role beneficiaries play in driving up the volume of these services.

I am also anxious to hear about MedPAC's research and recommendations in these areas, but also think that we need to proceed carefully. I have concerns and questions that need to be answered. For example, what would be the impact of your rec-

ommendations with regard to teaching hospitals that rely heavily on these funds? Can hospitals that operate on very slim margins or in the red like those in my State, will they continue to operate and provide the same level of services if they begin to lose GME funding?

I also worry about imposing new cost-sharing requirements on beneficiaries as part of a new value-based insurance design and the impact that might have on beneficiaries who might forego important treatment rather than pay a cost-sharing requirement. Also, in terms of value-based insurance designs, who decides what services are high-value, what services are low-value? These are important questions and I look forward to hearing the answers in today's hearing.

And finally, let me note that it would be inappropriate for the subcommittee to hold a hearing on Medicare payments and incentives without addressing the elephant in the room, which is the annual payment cut that doctors face. This year, as everyone knows, physicians participating in Medicare face a 21 percent cut. We have been able to prevent this cut from taking place thus far through a series of temporary delays.

As you know, before the Memorial Day recess, the House passed a bill that would provide another temporary reprieve to physicians by delaying that cut from being imposed and replacing the modest increase to the end of 2011. Our colleagues in the Senate have advocated for a shorter-term pared-down package—nothing new—and we have been unable to find agreement up to this point. So we all realize the need for swift action.

I don't have to tell you how many doctors come to my office—not so much here, but in New Jersey—complaining about the fact that they would like to see a permanent fix, which obviously we have also voted on in the House, but we can't get passed in the Senate. So the Democrats and the Republicans in both Houses as well as the physician community need to work together to develop a permanent fix. We simply can't continue to kick the can down the road.

I know I feel like I am talking to the choir here because the members on this committee are not, for the most part, the bad guys on this one. But we have to mention it.

So I want to recognize Mr. Shimkus.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Mr. Chairman. And thank you for joining us.

We all know that MedPAC is critical in advising us as we make legislative decisions to alter Medicare. We must find ways to reform entitlements, including Medicare, to make them sustainable into the future. By 2020, almost 93 cents of every dollar of Federal revenue will be spent on entitlements and net interest costs. By 2030, net interest payments on our Federal debt will exceed 8 percent. This will make interest payments the largest single expenditure in the Federal Government and leave little room for all other spending.

Change is necessary, but we should do what we can to avoid unintended consequences. MedPAC's June report raises concerns over rapid growth on ancillary services in physician offices. The report provides options to address growth in diagnostic imaging, radiation therapy and physical therapy in physician offices. These are very different services, and an option appropriate for one of these services may not be for the others. We must use caution to not paint all ancillary services with the same broad brush.

I am pleased to report it covers the graduate medical education system. I hear from hospitals already in my district all the time over the unmet need of residency slots and from the physician community on wanting more flexibility to train in settings outside the hospital. While I believe we must examine these GME issues, I am hesitant in removing 3.5 billion in funds hospitals rely on through their indirect medical education payments. I look forward to hearing more from MedPAC on working to strike a balance.

As we seek MedPAC's guidance for Medicare, what does the health reform law do to sustain quality and access to care? As Chairman Pallone mentioned, the new law does nothing to address the 21 percent cut. He didn't mention that. He did address the concern about the cut to our doctors now taking as a turnaway from Medicare patients. In Illinois, 18 percent of all doctors are now restricting the number of Medicare patients in their practice. That story just broke yesterday.

The law does, however, cut $500 billion from Medicare, billions of dollars in cuts that would not enhance the ability of the government to pay for future Medicare benefits, according to CBO. Medicare D premiums will rise for all of the nearly 28 million participants. Again, this is from the nonpartisan CBO. Half of seniors enrolled in Medicare Advantage will lose their plans, and all seniors will have access to care in hospitals jeopardized with the law, causing 15 percent of party hospitals to become unprofitable within 10 years, a figure CMS' own actuaries say may lead some to terminate their participation in Medicare entirely. And this is only some of the effects on Medicare.

Yesterday the President remarked the new law will cut costs, make coverage more affordable. Last month the CBO said the price tag is actually higher, with an additional 115 billion in discretionary spending. And before then CMS and the country will spend 310 billion more under the new law than we would have without it.

As for affordability, CBO concluded self-employed small business workers, early retirees and millions of other Americans who buy their own health insurance plans will pay on average $2,100 a year more. Again, yesterday we heard the President using the bully pulpit to tout the benefits to small businesses and the relief it would provide. But only 12 percent of businesses would see any relief at all, with even fewer eligible for the full tax credit. To get that full tax credit, you can only have 10 or fewer employees making an average of $25,000 or less. The message to employers is clear: Don't hire, and don't pay your current employees more.

Finally, the Majority continues to claim the high-risk pools provide immediate access to insurance to those uninsured because of preexisting conditions. Now, the high-risk pools are set to go on

line in July, and CBO tells us the number of people who may be eligible for this program is in the millions, yet enrollment will be around 200,000 people. And in Illinois, they will miss the deadline altogether and might start enrolling people in its pool mid to late August. For those in current high-risk pools in Illinois, they will pay higher premiums than those in the Federal one. Illinois will receive 196 million to set up the pool. That would cover only about 5,000 people between now and 2014; 5,000 people among its 2.5 million people in Illinois living with chronic conditions.

I warned as recently as last week that the 5 billion would not be enough to fill this need, and now those warnings are proving true. The Illinois insurance commissioner said this week demand will almost certainly outstrip funding, and eligibility will probably be limited at first to people with a fairly narrow list of health conditions. So the high-risk pool is going to pick and choose.

Not enough money, not meeting deadlines and limiting the enrollees. Can we honestly say to Americans we are providing immediate access to affordable insurance for those with preexisting conditions? If all these experts' analyses are true, shouldn't the committee hold hearings and take immediate action and address these problems? And if the claims are inaccurate, should we not clear the air? Republicans have asked for multiple hearings on the law, and wait as the deadline passes and promises to the American people are broken.

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

Mr. PALLONE. Thank you, Mr. Shimkus.

The gentlewoman from Florida, Ms. Castor.

OPENING STATEMENT OF HON. KATHY CASTOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Ms. CASTOR. Thank you very much, Mr. Chairman, for convening this hearing today.

And welcome, Mr. Hackbarth.

This hearing is vital to all of our parents and grandparents that rely on Medicare for their health care. It is also vital to all of our families as Medicare often sets the course for health care and health care delivery in America. So I am very encouraged by MedPAC's recommendations to continue to focus on the quality of care and increasing value of our health care delivery system.

I am also encouraged by MedPAC's concept of creating Medicare payment incentives as we improve quality. Chairman Hackbarth, you have mentioned in your testimony patients do not always receive the recommended care for their health conditions, and they may receive care that is not clinically appropriate, and this must continue to be our focus.

I have introduced legislation, the Eliminating Disparities in Breast Cancer Treatment Act, which speaks to some of the same strategies that is tying Medicare payments to quality care and rewarding efficiency and quality, And this will help to see that patients receive higher-quality care based upon the recommended quality standards.

And I am interested in hearing from MedPAC on incentives in the Medicare fee for services, a payment system that may be at the root of our primary care shortages if indeed the current payment

system, which, according to MedPAC, rewards volume and favors certain specialties which may be more lucrative simply because of higher volume of individual procedures offered as compared to primary care—this is something we have got to continue to address beyond what we have already done in the health reform area.

I am also very concerned where we stand on graduate medical education, and you see where we start puts my home State in Florida—we are in such a deep hole, I am very concerned if we go full speed ahead on reform, Florida is going to continue to be left behind. You see, we are the fourth largest State in the country, very dynamic State with strong medical schools, and we are 44th in the number of medical residencies. So that means that the folks I represent may not be getting the care that they need because oftentimes those doctors in training, they will go and take their residency in another State, and they don't come back. So I want to get into that discussion with you today.

We also have an aging physician population, one-quarter over the age of 65 in my State. So you can see we have a looming crisis on our hands.

So I look forward to hearing from you on all of these issues as we continue to ensure that health care reform works for all American families.

Mr. PALLONE. Thank you, Ms. Castor.

Ranking member, Mr. Barton.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Mr. Chairman.

I want to thank Mr. Hackbarth for testifying before the committee today. MedPAC provides a valuable service to Congress. We always appreciate the candid and detailed analysis of the Medicare program that they give.

I am pleased to see that MedPAC has addressed graduate medical education and has recommended ways to encourage teaching programs that emphasize nonhospital care and care coordination, focus on the delivery of efficient, quality care.

Just recently we learned that a number of doctors are now refusing to take new Medicare patients because government reimbursement rates are so low. It is simply too costly for those doctors to take new patients. We are hearing this at a time when baby boomers are increasingly entering the program. Meanwhile, the Majority has failed to fix Medicare's sustainable growth rate, or SGR, resulting in a 21 percent cut in payments to doctors. Thus it is imperative that we listen to MedPAC's advice on how to produce professionals with the skills to practice in the Medicare system now more than ever.

The recommendations in this report only scratch the surface of what must be done not only in Medicare, but our entire health care system. We are only a few months into the implementation of the new health care law pushed through recently on a purely partisan vote. We already see strong evidence that the new law is not solving our health care problems; rather, it is increasing costs and crippling health care.

I think it is a fair observation that the evidence is mounting on how and when President Obama's new law will make health care worse for many Americans. Internal documents requested by the Majority show that companies across the country are engaged in a serious discussion about dropping health care coverage for their employees. It looks like the increased costs and disincentives of the law are simply more than many employers can afford in the middle of a recession.

Finally, we also understand something all too well now that President Obama would not admit when his health care bill was up for debate. It will strangle Medicare. The chief actuary of Medicare now reports that the health care law just passed cuts approximately $575 billion from Medicare over the next 10 years.

Mr. Chairman, I think it is a good thing that you have called this hearing. I look forward to our witness and then asking questions. Thank you.

Mr. PALLONE. Thank you, Mr. Barton.

[The prepared statement of Mr. Barton follows:]

The Honorable Joe Barton
Committee on Energy and Commerce
Subcommittee on Health
MedPAC's June 2010 Report to Congress: Aligning Incentives in Medicare
June 23, 2010

Thank you, Mr. Chairman.

I want to thank Mr. Hackbarth for testifying before the Committee today. MedPAC provides a valuable service to Congress and we always appreciate their candid and detailed analysis of the Medicare program.

MedPAC's June report contains many valuable insights on how to improve the efficiency and quality of Medicare, and I thank Mr. Hackbarth and his colleagues for their recommendations.

In particular, I am pleased to see that MedPAC has addressed graduate medical education and has recommended ways to encourage teaching programs that emphasize non-hospital care and care coordination, and focus on the delivery of efficient, quality care. Just this week, we learned that a number of doctors are now refusing to take new Medicare patients because government reimbursement rates are so low. It is simply too costly for these doctors to take new patients. And we are hearing this at a time when Baby Boomers are increasingly entering the program. Meanwhile, the Majority has failed to fix Medicare's Sustainable Growth Rate—resulting in a 21% cut in payments to doctors. Thus, we need MedPAC's advice on how to produce professionals with the skill to practice in the Medicare system now more than ever.

Yet, these recommendations only scratched the surface of what must be done not only in Medicare, but our entire health care system. We are only a few months into implementation of the new health care law that the majority pushed through on a purely partisan vote. Yet we are already seeing strong evidence that the new law is not solving our health care problems; rather, it is increasing costs while crippling our health care.

I think it's a fair observation that evidence is mounting on how and when President Obama's new health care law will make health care worse for so many Americans. Internal documents—requested by the majority—show that companies across the country are engaged in serious discussions about dropping health coverage for their employees. It looks like the increased costs and disincentives of the law are simply more than many employers can afford in the middle of a recession,

and maybe anytime. The president's idea that we're all in this together ignores the laws of economics that dictate what happens to the workers when their employer goes broke. Regulations proposed by the president's Health and Human Services Department make it more likely that more than half of all employees will lose their current coverage by 2013.

And, finally, we understand something all too well now that President Obama would not admit when his health care bill was up for debate: It will strangle Medicare. The Chief Actuary of Medicare now reports that the health care law cuts approximately $575 billion from Medicare over the next ten years.

I am glad that a representative from MedPAC is here to testify today, so we might learn more about these deep wounds

and how they will affect real people living real lives. I want to know everything that can be known about what we should do to ensure a functioning Medicare program into the future.

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

Mr. PALLONE. Next is chairman emeritus Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Thank you, Mr. Chairman. I commend you for the hearing.

Established in 1997, the Medicare Payment Advisory Commission has provided invaluable advice to the Congress concerning the Medicare program. Through their biannual reports, they have consistently advocated for a more efficient Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, and spends Federal tax dollars properly.

It is important to note that many of the recommendations included in the recent MedPAC reports, including many recommendations in the current report, were included in the landmark health care reform legislation passed by the Congress and signed by President Obama earlier this year. These regulations include providing a payment bonus to physicians who practice primary care, reducing payments to hospitals with high preventable readmission rates, and testing the feasibility of a bundled payment for an episode of care. This is a testimony to the efforts of the sponsors of that bill and the administration to do all we can to make the Medicare program and, indirectly, private insurance a smarter, more efficient deliverer and payer for high-quality health care.

In addition to the work accomplished by the new health reform law, MedPAC has provided a number of additional recommendations to consider on ways to improve the ability of the Center for Medicare and Medicaid Services to innovate, ensure the health care workforce is adequately trained, and to assist Medicare beneficiaries in making better decisions about the course of their health care treatment.

I look forward to Mr. Hackbarth's testimony. I look forward to spending more time exploring the goals and the impact, both direct and indirect, to the recommendations included in the June report, and I hope that this subcommittee and committee will do so alike.

Finally, I am very interested in exploring MedPAC's future relationship with the new, independent Payment Advisory Board created by the new health reform law. This legislation envisions some interaction between the two. It is my hope that will occur, but that it will occur in a beneficial way. However, we must think very carefully about how the two entities coexist beyond the specifics of the legislation, and this committee must again direct its attention to that.

So thank you very much, Mr. Chairman. I yield back 2 minutes and 10 seconds.

Mr. PALLONE. Thank you, Chairman Dingell.

Next we will go to the gentleman from Kentucky Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman. I am going to waive my opening statement.

Mr. PALLONE. And next is the gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman, for holding this hearing on MedPAC's latest report to Congress, and our thanks to Mr. Hackbarth and the members of MedPAC for your work on the report and for being here to testify today.

I just can't help but say something before I make the rest of my remarks. My friend from Illinois keeps hacking away at the national health care plan which we passed in talking about the cuts to Medicare. I think that we need to get the record set straight. There are—or were insurers in the country that were receiving up to 135 percent more in payments than others. So while it is called Medicare Advantage for some of my constituents, it was clearly Medicare Disadvantage for other constituents. Now, all of those moneys that went into the overpayments for those insurers are being plowed back into Medicare. So I think we need to keep—we all have our opinions——

Mr. SHIMKUS. Would the gentlelady yield?

Ms. ESHOO. No. I am not going to yield. No. It is my time. But to just try and shape—to pretend that something is a fact when it is not——

Mr. SHIMKUS. Is the gentlelady questioning my——

Ms. ESHOO. No, no, no.

Mr. GREEN [continuing]. Out of order.

Ms. ESHOO. Anyway, getting back to our hearing today, I am very pleased that a significant portion of your report, Mr. Hackbarth, focuses on the signals that Medicare sends to medical students through the GME financing, the graduate medical financing. From the point of view of hospitals, though, not all residencies are created equal. And I think that this is something that—and Medicare largely funds them as if they were.

I think that we have had a long struggle with the problem that medical students are choosing to subspecialize rather than choose family care or primary care, which is one of the things that we, I think, addressed in the health care legislation, and Medicare-supported residency slots, I think, should aim to create the correct proportion of specialists and not just the current proportions. And I think this is a discussion we have to continue to have, especially in view of the millions of Americans soon to be insured.

So I look forward to your testimony, and I thank you for your work. And I thank the chairman for calling this important hearing.

Mr. PALLONE. Thank you, Ms. Eshoo.

Next is the gentleman from Georgia, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Thank you, Mr. Chairman.

Mr. Chairman, our Medicare program is facing a dark future made worse by President Obama's health reform law that this Congress passed back in March. As Chairman Hackbarth will outline in his testimony, the Medicare Hospital Trust Fund's expenses exceeded its income in 2008, meaning that its current trajectory is

unsustainable. This path, if left unaddressed, could rob future generations of quality Medicare benefits.

Over the last 18 months, Democrats in Congress cut $500 billion from the Medicare program in order to help pay for President Obama's health care bill. And by the way, the gentlelady from California Ms. Eshoo says that that $500 billion cut of Medicare, much of which comes from Medicare Advantage, was plowed right back into the Medicare program. Nothing could be further from the truth. In fact, I have an amendment when the bill was marked up in the House, H.R. 3200, that would have affected that, but it was rejected by the Democratic Majority. The Majority said the $500 billion came from ending waste, fraud and abuse. CMS actuary Robert Foster countered that argument by stating that the cuts would result in 9.4 million seniors losing their current Medicare benefits primarily in the Medicare Advantage program and paying higher out-of-pocket costs for their health care. Make no mistake, seniors' costs will go up because of Obama care.

Congress could have used that money to cap out-of-pocket expenses or help offset doubles under Medicare in order to truly lower health care costs for lower-income seniors with chronic illnesses, but the Democratic Majority could have put those funds back into the Medicare Trust Fund so that seniors don't wake up one day soon and find their health care program bankrupt. Speaker Pelosi could have taken that 500 billion and permanently addressed the physician payment crisis under Medicare that is currently threatening our seniors' access to quality care.

If cutting $500 billion from a Medicare program that is going broke does not worry seniors enough, the President is now pushing Dr. Donald Berwick for the post of CMS Administrator. He is a self-described proponent of rationing health care from sick Americans. A New York Times piece that ran just yesterday quotes Dr. Berwick as, quote, "in love with the British health care system," unquote, and stating that, quote, "the national health system is not just a national treasure, it is a global treasure," unquote. This is the same British system that routinely makes coverage decisions based on cost and life expectancy. This is the same British system that denied coverage for the breast cancer drug Herceptin because it was not deemed cost-effective. It took a protest march by thousands of women in the streets of London to change that decision. Simply put, our seniors' health care program cannot afford Dr. Berwick.

Mr. Hackbarth, with these thoughts in mind, I look forward to your testimony today. You and your staff have served this Congress well, offering technical advice and insight into ways that we might restructure our Medicare program so that seniors' health care and needs and taxpayer interests are indeed safeguarded.

Particularly I am interested in your thoughts on how we might overhaul our current system of reimbursing physicians under Medicare, the sustainable growth rate, and how properly aligning incentives in the program might encourage a greater efficiency and collaboration.

With that, Mr. Chairman, I yield back, and I thank you for your patience.

Mr. PALLONE. Thank you.

Next is our chairman, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Chairman Pallone, for calling this hearing.

We are going to hear from a representative of MedPAC, which is an organization set up to advise the Congress about the Medicare program, and they have done an excellent job over the years. In fact, many of their recommendations were incorporated into the recently passed comprehensive health insurance bill. That bill is going to extend health insurance coverage to 50—to 30 million Americans. It is going to hold down costs, and it is going to benefit the Medicare beneficiaries.

You wouldn't believe it by the propaganda line we have gotten from the Republican side of the aisle. They were against working on a bipartisan basis with us. They complained about the bill before it was enacted; they have complained about the bill since it has been enacted, and it is not even implemented.

But some things are going to be implemented. For example, we heard about the high-risk pools being a failure. The high-risk pools are a temporary way to cover people with preexisting medical conditions who cannot buy insurance at all. Well, this will give them a chance to buy insurance until the insurance system is implemented where they can no longer be discriminated against, something the Republicans would not support.

They have complained that this is going to do a disservice to Medicare. Well, the truth of the matter is that the Medicare Trust Fund is going to be extended for many, many years. The Medicare Trust Fund will be extended for 12 years, to 2029.

They have talked about some of the cuts in Medicare, but those cuts are wasteful expenditures to insurance companies that are telling Medicare beneficiaries that they should have more money for their overhead. We said, no, the money ought to go for health care services, and this was one of the recommendations of MedPAC, not to have these so-called Medicare Advantage plans get overly compensated.

But not only are we saving money in the expenditures of Medicare, we are also going to be closing the doughnut hole so seniors will not find themselves going broke having to pay 100 percent of the full cost for their prescription drugs, something the Republicans provided for when they adopted their original Part D Medicare legislation. We will close the doughnut hole.

We will provide preventive services without costs to the seniors. They won't have to come in with copayments. We extended the life of the Medicare Trust Fund.

You would think we ended Medicare. You would have thought we were putting the American people on the British system, to hear my colleague from Georgia a minute ago talking about the result of the health care bill.

The hearing we are having today is not the first hearing we have had on the whole health care system. The Congress of the United States, in fact the House, held 79 bipartisan hearings and markups

on health insurance reform over the past 2 years. We had hearings. We got full input from everybody, people who had different points of view, those that were in favor and those who were against. And out of those hearings, we worked on legislation, but we had to do it on a partisan basis, because like every bill that we have considered in the last year and a half, the Republicans have decided to vote no. They voted no on the stimulus bill. They voted no on the energy bill. They voted no on the health bill. They voted no on the financial reform bill. They are the party of no. And now when we are trying to learn more about what we need to do to keep Medicare the program it is as a way to provide health care services for our seniors and our disabled people, they want to complain, not talk about how we can work together.

MedPAC is giving us a report. That is the reason for this hearing. Their report is always useful. They have suggested that there are ways we should deal with graduate medical education to try to get physician services based more on quality and not on quantity. They are recommending what we should do with people who are both Medicare and Medicaid—the dually eligibles. They have given us a lot of good, substantive things to look at and to work on, and I am pleased with what they have done in the past, that has been part of the health care bill that is now law. And I am looking forward to the testimony and about further things we need to do to strengthen the Medicare program.

But let no one be fooled. What we are seeing is a lot of propaganda from our Republican colleagues, and it is the same thing we have heard at every hearing over and over again, that you are going to have rationed care, you are not going to have care, that everybody is going to drop the care, and meanwhile they wouldn't even eliminate the barrier for people to buy insurance because of preexisting medical conditions.

I am glad the health care bill passed, and the American people will welcome it as it goes into effect.

Yield back.

Mr. PALLONE. Thank you.

[The prepared statement of Mr. Waxman follows:]

Statement of Representative Henry A. Waxman
Chairman, Committee on Energy and Commerce
Subcommittee on Health Hearing on "MedPAC's June 2010 Report to Congress: Aligning Incentives in Medicare"
June 23, 2010

I thank Chairman Pallone for holding this hearing on this important report.

I am pleased we will hear testimony today from the Medicare Payment Advisory Commission (MedPAC). I thank Glenn Hackbarth, the MedPAC chairman, for appearing before us today.

As Members of this Committee know, we spent a great deal of time over the past two years studying recommendations from experts like MedPAC regarding the future direction of Medicare. Many recommendations from MedPAC were enacted by health reform legislation passed this March, including:

- The implementation of pay-for-quality in Medicare. This will assure that in the future hospitals, health plans, physicians, and other providers will be held accountable for the quality of care they provide rather than receiving payments just for the volume of services they bill.

- Reducing overpayments to Medicare Advantage plans – so that private plans don't pad their profit margins at taxpayer expense. Right now, overpayments to Medicare Advantage plans increase premiums paid by beneficiaries.

- Increased payments for primary care practitioners in Medicare – to help address the national shortage of primary care physicians affecting all patients, whether in Medicare, Medicare, or commercial health insurance.

In combination with other reforms, these changes extended the life of the Medicare trust fund by 12 years, to 2029.

In addition, outside the scope of MedPAC recommendations, we strengthened Medicare by filling in the donut hole for prescription drug costs in Part D. This has already started to help make drugs more affordable for seniors, and will help approximately 4 million seniors and people with disabilities by the end of this year.

But this hearing is not about what we've already accomplished; it is about the work that remains before us. The report raises many important issues and makes several recommendations to improve the Medicare program, but I want to highlight just two of these.

The report makes important new recommendations about the residency training of our nation's doctors. Medicare is the single largest payer of graduate medical education. Without question Medicare provides important financial assistance and aids in the training of highly-qualified providers. However, the Commission's report highlights a pressing need to ensure that the Medicare GME program supports the principal goals of delivery system reform – quality, efficiency, and care coordination and integration. We must work to guarantee this program produces the providers we need with the requisite skills to practice in the 21st century health care system.

Another issue the report analyzes is the poor state of care for individuals eligible for Medicare and Medicare – the so-called "dually eligible." Dually eligible individuals are among our nation's frailest and sickest people. Many are disabled, have cognitive impairments, and have multiple chronic conditions. Their health care costs are also very expensive – about $26,000 per person, per year in combined spending in 2005. Too often care for these people is fragmented, with no one ultimately responsible for ensuring that these enrollees have the best quality care when they need it.

The report also calls attention to opportunities to make Medicare a more innovative purchaser. Considering the challenges facing Medicare over the next decade, I believe we have to investigate these proposals to make better use of taxpayer dollars. In particular, I look forward to opportunities to enhance Medicare's ability to conduct research and demonstrations on innovative new payment models such as the medical home and bundled payments. These and other proposals hold the promise of improving quality in the program while reducing costs.

Thank you.

Mr. PALLONE. Next is the gentlewoman from Tennessee, Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Mr. Hackbarth, we are pleased that you are here. As you can see, we are going to have a very robust discussion today. I know you are looking forward to it.

And I think we all agree that there are some improvements that are needed in the current delivery system. But I will have to tell you, there is a lot of concern out there that Obamacare is going to be detrimental to Medicare, and that it has the potential not only to cripple the Nation's health going forward, but also to cripple and compromise those health care delivery systems.

And most recently we have had concerns expressed from physicians, and I know you are hearing this, too, about being able to meet the cost of their practices while they are facing reductions even to the point of phasing out of programs like Medicare Advantage. And yesterday there was a USA Today article, and I am sure you probably saw this. There was a quote in there, the number of doctors refusing new Medicare patients because of low government payment rates is setting a new high. And this is of concern to us. The AMA has even reported that 31 percent of primary care physicians are no longer accepting new Medicare patients. We are hearing quite a bit about this, and what we hear is that this 21 percent reduction in the SGR is forcing more doctors to make those reductions and dropping patients, and seniors are very concerned about this.

Now, I think that they are speaking up in expressing concerns, and one of the reasons we want to hear from you is because my colleague across the aisle just said we are the party of no. I would change that to—for him. We are the party of K–N-O–W, know, and what we have worked diligently to do is make certain that seniors have the information in front of them, whether it is about their Medicare Advantage and their concerns of that program being phased out, or whether it is about the current Medicare coverage that they have. And they continue to come to us and say, we thought we were going to be able to keep the benefits and the programs that we have, but we don't see how this is going to work. And what we are hearing from insurers is that changes are coming towards us, and when you see numbers like 136 billion being cut out of Medicare Advantage over the next 10 years, this is of concern.

I will also highlight that we have to remember that our seniors, today's seniors, have prepaid their access to Medicare, and we need to be mindful of that. We need to be respectful of that, and we welcome your insight and look forward to the hearing.

I yield back.

Mr. PALLONE. Thank you, Mrs. Blackburn.

Next for an opening statement is the gentlewoman from the Virgin Islands, Mrs. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And thank you and Ranking Member Shimkus for holding this hearing.

And thank you, Dr. Hackbarth, for joining us this afternoon to report on the Commission's June 2010 report to Congress.

The Medicare program has been in many ways an indispensable asset to the American elderly and disabled, and I welcome every opportunity to review and discuss aspects of the program that can be improved to increase the efficiency and quality of health care given to these populations.

Approximately 20 percent of the enrollees served through Medicare are racial and ethnic minorities, and roughly half of all beneficiaries are within 200 percent of the Federal poverty line. This is significant because these are the very beneficiaries who are extremely vulnerable, who suffer most detrimentally from health care inequities within the current health care system.

Although Medicare provides health care access to millions of Americans who otherwise would go without coverage, the fact remains that prior to enrollment in Medicare, most were either uninsured or grossly underinsured, two scenarios that we know have deleterious health impacts. This means often by the time they enroll in Medicare, many of the health issues that may have been—might have been addressed relatively easy with access to care have now been compounded and exacerbated by a lack of care or poor care when it was available.

Because of this, it was especially interesting to me to read the recommendations of the Commission, particularly as it pertained to focusing more on a payment method that encourages quality over quantity service, and promoting more participation from both patient and provider in the decisionmaking process, and in attracting a more racially and ethnically, geographically and socioeconomically diverse health care workforce.

I am interested also in hearing more about how MedPAC suggests addressing the numerous health disparities that have been documented within the Nation's Medicare population.

And so, again, I thank you for today's hearing, and I look forward to a very informative and thought-provoking discussion.

Thank you, Mr. Chair. I yield back.

Mr. PALLONE. Thank you, Mrs. Christensen.

Next for an opening statement, the gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

And a couple of reasons why today's hearing is notable. Once again we have a chance to hear from our good friend Mr. Hackbarth, who is no stranger to this committee. Time for us to dig down deep and take a look at whether Medicare does a good job of shepherding the enormous resources available to the program to provide health coverage for millions of older Americans. That is the larger and the grander goal.

But today is also notable because doctors across the country who participate in the Medicare system are receiving 21 percent less for the services they performed last month for taking care of all of our Nation's sickest and most needy patients. Congress has broken the contract that we have with the Nation's seniors and the Nation's physicians by allowing this dramatic cut to take place.

Let me point out I have voted for some very bad policy in the past, very bad policy that had at its base stopping those cuts from occurring. Unfortunately, we have not had—in all the hearings that were referenced by Chairman Waxman, we have not had since 2006 a hearing on the sustainable growth rate formula, and I think it is time we do that.

I have a bill, 3693. I would like to see that get a full and fair hearing. Since this committee will not hold a hearing next month, I will be holding a forum by myself to talk about this very issue.

And then what is worse is we have the Speaker, astonishing in her cruelty, holding up a bill. OK, the bill is delinquent, maybe criminally so; it is insufficient, perhaps scandalously so; but still it is a reprieve for the Nation's seniors and doctors, but the Speaker won't let it come to the floor because it doesn't comport with everything that she wants. I voted for very bad policy in the past just to prevent these problems from happening to our seniors and doctors. The Speaker should do the same thing.

Very few Members of Congress, outside the physician Members, have any appreciation for what this delay and our inaction does to physician practices. When you have a small physician practice, even with as small a population as 15 percent Medicare, and you don't get paid for 3 weeks, that is a big deal. This decision will lead businesses to closing and patients losing their doctor.

We have got price controls in this country. Most of us don't admit that in health care, but we do. Every private insurance company in the country pegs to what we do in Medicare. That is why it is so critically important that we get off our duff and do the right thing.

We talk about the fact that people aren't going into the specialties that we want them to go into. We have administrative pricing. We are driving people, driving people into the specialties that we now decry and keeping them out of the specialties we wish they would go into. But we are doing it by our administrative pricing.

What about quality over quantity? When the only lever you pull is to rachet down reimbursement rates, the only lever the doctor has to pull is to increase the number of hours they work or work a little harder, spend a little bit less time with each patient. The only way they can pay their overhead—and let me remind members of this committee that doctors who would see patients in the Medicare program have not had any increase in their reimbursement since the year 2000.

Now, I know we need a long-term strategy, and I have not always agreed with MedPAC's findings on the sheer amount of money and layer upon layer of bureaucracy that defines our current program. But that in and of itself calls out for a dramatic rethinking of the program. As a committee we do need to have a bipartisan dialogue. Unfortunately, Mr. Waxman has left, but I would remind him that I met with him early in 2009 to talk about

was there a possibility to work in a bipartisan fashion on this health care bill. I have met with the transition team in November of 2008 to ask that very same question. I got no response as an answer. What did we get? We got a bill thrown over the transom on July 15th, and then we were brought to committee and told to mark it up.

Mr. PALLONE. Dr. Burgess——

Mr. BURGESS. I had 50 amendments on that—I had my own table for amendments, and yet you say that the Republicans refused to participate.

Mr. PALLONE. All right.

Mr. BURGESS. Where do you get this stuff? Do you just make it up?

Mr. PALLONE. You got it. You are over a minute, Dr. Burgess.

Mr. BURGESS. I thank the chairman for his indulgence. I look forward to the hearing we are going to have on the SGR formula in short order, and we might also bring——

Mr. PALLONE. I am going to have to rule you out of order.

Mr. BURGESS [continuing]. And talk about the administrative function——

Mr. PALLONE. You are a minute over. I recognize Mr. Barrow.

Mr. BARROW. I thank the chair. In the interest of time, I will waive an opening.

Mr. PALLONE. No, he is not yielding to you.

Mr. Murphy of Pennsylvania.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman.

It is good to have you here today, sir. I am looking forward to a number of things. I am looking forward to reading this book. I am going to draw the committee's attention to something very important in the executive summary where you say Medicare oftentimes lacks the authority to deal with some prospective payment systems that would improve payment accuracy. Similarly, a change in law is also necessary for Medicare to implement policies that pay providers based on their quality. Medicare needs authority to make such changes in its current payment system.

A while ago, when our new President took office, I sent letters to his staff and other folks asking that Congress and the White House put together a blue ribbon panel to really review Medicare, which was designed in 1965 and designed really from the bottom up. What would Medicare look like if we designed it now in 2010? Back when it was designed, as you know, some of the most advanced instruments hospitals had was an X-ray machine on wheels. We obviously have come a long way since then. And back then it worked then, with the limited things we had with medications and other treatments, to pay a fee-for-service system. Now we have a substantial amount of research which says that quality is important, and that care management is important, and those things can indeed save money.

When we look at some of the things that happen now in Medicare, and it will be interesting to hear your comments on this, it

looks like many of the things require an act of Congress to change it. For example, we are still in a system that doesn't pay for someone in the nurse's office to coordinate care even though that call to a diabetic is far cheaper than amputating a diabetic's legs. Stroke victims oftentimes can save money if you have a teleconference video, but that depends on where that hospital is, rural versus suburban, even if both are an equal distance in time by ambulance to the base hospital. Home infusion therapies are still limited even though some of those save time and reduce the risk for infection.

There are also things that have to do with how we even order wheelchairs and canes, and deal with wage indexes that on the east side of Harrisburg in Pennsylvania may get paid one way and the west side of Harrisburg in Pennsylvania may get paid a rate that is so much lower, the doctors can't handle it.

It is of concern, and I am pleased you are addressing this issue that we cannot expect to prop up a system of Medicare that is struggling financially just with saying we are not going to pay. I believe the analogy we all understand is if someone comes to work on our home, and we can have two estimates, one will say it is going to cost you this much to fix your roof, and another guy will say, I am just going to charge you for each item I put up there and my hourly rate. We all know which one is going to cost a lot more. In each case we are just looking to have the roof fixed.

I hope that you can let us know, if not in today's hearing, in the future. It is extremely important to this committee and to me that we have got to revise this system of Medicare and make it up to date and give Medicare the flexibility to redesign itself as we have more breakthrough information in how we can best administer medicine. Putting it on the backs of physicians and saying we are not going to pay you isn't going to work.

Thank you so much. I yield back.

Mr. PALLONE. Thank you, Mr. Murphy.

The gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I would like to waive opening statement, but also remind my Republican colleagues the health care bill that came out of the House had a permanent fix of the SGR. In lockstep, my Republican colleagues voted against it.

Mr. BURGESS. Will the gentleman yield?

Mr. PALLONE. I think the gentleman actually waived his—well, not waived—didn't use his time, but somehow managed to get a statement in as well. So I don't know.

Anyway, let us move on to Ms. Schakowsky, who is recognized.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, for this opportunity to discuss MedPAC's June 2010 report to Congress.

I want to thank Mr. Hackbarth for appearing before the committee, and thank the staff at MedPAC for their work putting this together.

Today's hearing is about improving the access to and effectiveness of Medicare. This Congress has implemented historic reforms

to our broken health care system that takes gigantic steps forward to improve access and quality in health care for millions of Americans. We have extended the Medicare Trust Fund by an additional 12 years so that we can keep our promise to older Americans and disabled Americans. We have done what MedPAC has recommended that we do for years, which is to cut excess payments to private insurance companies for Medicare Advantage. We have eliminated cost sharing for preventive care in the Medicare program, and we are getting rid of the Republican-created doughnut hole. Moreover, health reform will reduce the national deficit by more than $100 billion in the first decade, $1 trillion in the decade after that.

Your testimony discusses the highly unpredictable and highly variable cost of Medicare cost sharing. It is a point I fear many miss. According to AARP, people on Medicare spend an average of 30 percent of their income on out-of-pocket health care costs, including premiums for supplemental coverage. As cochair of the seniors' task force, I often hear from constituents who pay hundreds of dollars a month for their Medicare. In 2010, it is $110.50 for most Part B premiums. The Kaiser Family Foundation reports that Part D premiums or prescription drug plans have jumped by 50 percent since 2006. And MedPAC's March report shows substantial increases in cost-sharing requirements for both brand name and generics in 2010.

Finally, the NAIC statistics from a recent MedPAC report show that Medigap coverage costs—policyholders pay 2,000 to $3,000 a year. Medigap policies are expensive, but they can protect against highly variable and unpredictable out-of-pocket expenses that you reference in your testimony. It is critical to note that Medigap policies aren't being used by people trying to shirk their health care responsibilities. They are being used by Americans who are a bit too rich for Medicaid, but don't have the savings to pay for potentially devastating, uncertain medical expenses.

I look forward to hearing your testimony today, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

The gentleman from Ohio, Mr. Space.

Mr. SPACE. I will waive my opening, Mr. Chairman.

Mr. PALLONE. The gentleman waives.

I think that concludes our opening statements. So we will go now to our witness. First of all, let me welcome you again. I know you have been here before, and we always enjoy your insight. We have limited you to 5 minutes. I hope that is OK. If you need more, you can use it because you are the only witness. And if you would proceed. Thank you.

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

Mr. HACKBARTH. Thank you, Chairman Pallone, Ranking Member Shimkus and other distinguished members of the subcommittee. I welcome this chance to talk about our June 2010 report to Congress.

Let me begin by briefly reminding you about exactly who we are and how we do our work. MedPAC is a nonpartisan advisory group.

We have 17 members. The process for appointing the members is run by GAO. The Commission that produced the June report had six physicians and one registered nurse on the Commission. In addition, we had five Commissioners that had executive-level experience in running health care delivery organizations. Another five had had experience in running private health plans. And some Commissioners have more than one of these credentials in their background.

As Chairman of MedPAC, I believe we can best serve the interests of Congress by wherever possible finding a consensus point of view among these diverse perspectives included on MedPAC. Usually we succeed in doing that, and just to illustrate that point we have published two reports to Congress this year, March and June. In total there are 26 recommendations in those 2 reports, which represents roughly 400 individual votes by MedPAC Commissioners. On this 400 individual votes were zero no votes and 3 abstentions. So we are able to take a diverse group of people, diverse group of experiences in health care, and find common ground on how to improve the Medicare program.

Our examination of any given issue usually spans multiple public meetings. We have eight public meetings a year and often will take up a complex topic, have discussions that explore the available information, ask our staff for additional analysis, then we begin the discussion of options. At each point of the process, we reach out to parties in the outside world that would be affected by the recommendations who have expertise to bring to bear and make sure we have the benefit of that information. So it can be a rather lengthy process to getting to final recommendations, but we believe that approach allows us to provide the best possible advice to the Congress.

To provide a little bit of context for our discussion of the June report, I thought it would be useful for me to highlight some of the areas where MedPAC has made recommendations in the past and where there is a strong consensus among Commissioners. First and perhaps foremost is that Medicare simply cannot go on as it is. The rate of growth and expenditures eventually will become unacceptable, and so we need to look in every way possible to find ways to slow the rate of growth in Medicare expenditures while preserving or hopefully improving quality and access to care.

To slow growth and increase value for Medicare beneficiaries, we will have to act in a broad front; there is no single thing that we can do. Among the recommendations that we have made in the past are there needs to be consistent pressure applied to the unit prices for individual services, whether they be for physician services, hospital services, home health agency services, whatever the provider type.

We need to look for ways to change the relative values of payment. Some of the Members earlier mentioned primary care physicians versus subspecialty physicians. We need to look at opportunities to change those relative values in a way that signals which sort of care Medicare beneficiaries need more of and reward the provision of that care.

Third, we need to look at reforming payment methods, using new payment methods, whether that is paying for quality or bundling

services around hospital admissions, medical home. Those are several examples of what we consider to be payment reform.

Fourth, there is a broad consensus within the Commission that we need a robust and value-focused Medicare Advantage program, because private plans have the ability potentially to do things that traditional Medicare finds difficult.

And finally, and most relevant for our June 2010 report, we think it is important for Medicare to begin the process of reforming its contributions to graduate medical education. And, Mr. Chairman, I would like to close with just a few comments about graduate medical education.

I have a slide here that briefly summarizes our recommendations. In the interest of time, I am not going to go through all of the points in the slide. I would like to focus instead on the context for our recommendations.

MedPAC Commissioners believe that our system of graduate medical education is in many respects the envy of the world. The system produces thousands of superbly skilled physicians each year, physicians who are trained to apply the latest technology, latest technique to aid Medicare patients and other patients in need. On the other hand, there is a broad consensus within the Commission that the current GME system is not consistently producing the physicians we need to reorient our health care system toward a higher level of performance.

Mr. PALLONE. Mr. Hackbarth, I cannot read that. I must be getting old. Is that in the book somewhere?

Mr. HACKBARTH. Yes, it is. Actually, I will have somebody behind me find the page, and I will tell you what the page is.

Page 103 in the red book, the June——

Mr. PALLONE. Thank you.

Mr. HACKBARTH. So another element of the consensus within MedPAC is that the GME system is not consistently producing the physicians we need to move towards a higher-value health care system, and I would emphasize that is not just our judgment, that is the judgment of many other people that we consulted with, including many people within the graduate medical education system itself.

Broadly speaking, we find two types of deficits in the GME system. One is in the mix of physicians being produced by the system. That includes the specialty mix, the number of primary care physicians relative to subspecialty physicians and the like. But it also includes the racial, ethnic and geographical diversity of the physicians we train.

The other area of deficit is in the content of training. While physicians are very well trained in advanced technology and techniques, we are concerned, as are many others, that there are important areas that are not as well focused upon, including evidence-based medicine, cost awareness, team-based care, care coordination, shared decision making with patients and the like.

It is important to emphasize that as MedPAC sees it, the GME system does not bear full responsibility for these deficits. For example, in the area of specialty mix, Medicare payment policies and those of private insurers strongly influence the choices that physi-

cians in training make. They also influence the sort of training programs that teaching institutions decide to engage in.

Moreover, I would add that the GME system deserves credit for its efforts to reform the content of training. For roughly the last decade, ACGME, the accrediting body for graduate medical education has been engaged in what they refer to as an outcomes project which is designed to refocus training on new skills that physicians need to produce high value health care. We believe that that movement is largely in the right direction, but we think that the pace needs to be accelerated. And we propose to do that by making a portion of Medicare funding contingent on the development of and adherence to new standards of performance for graduate medical education.

And we urge that all of the relevant voices be included in developing those standards not just people involved in academic medicine but also representatives of patients, purchasers and high-performing delivery systems.

Thank you, Mr. Chairman. Those are my opening remarks. I look forward to your questions.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Aligning Incentives in Medicare

June 23, 2010

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001 • 202-220-3700 • Fax: 202-220-3759 • www.medpac.gov

Chairman Waxman, Chairman Pallone, Ranking Member Barton, Ranking Member Shimkus, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to share the findings from our June 2010 *Report to the Congress*: *Aligning Incentives in Medicare.*

Current challenges in Medicare

Since 1997, MedPAC has provided independent, non-partisan 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.

However, numerous indicators suggest that goal is not being realized. Many studies show serious quality problems in the American health care system. Some individuals are not receiving the recommended care for their health conditions and others are receiving care that may not be clinically appropriate—care that does not appear to be related to improving patient outcomes or quality.

These shortcomings have significant fiscal consequences for the federal government. The share of the nation's GDP committed to Medicare is projected to grow to unprecedented levels, squeezing other priorities in the federal budget and constituting a growing financial liability for beneficiaries and taxpayers. The Medicare trustees reported the Hospital Insurance trust fund's expenses exceeded its income in 2008 and have expressed serious concern about its possible exhaustion in the future.[1]

Many of the barriers that prevent Medicare from improving quality and controlling costs—obtaining better value—stem from the incentives in Medicare's payment systems. Medicare's payment systems are primarily fee-for-service (FFS). That is, Medicare pays for each service delivered to a beneficiary by a provider meeting the conditions of participation for the program. FFS payment systems reward providers who increase the volume of services they provide

[1] The 2010 trustees report is expected later this summer in order to reflect on recent legislative activity.

regardless of the benefit of the service. FFS systems are not designed to reward higher quality. (While much of MedPAC's work has focused on problems in the Medicare FFS payment systems, the Commission has also documented flaws in the payment system for Medicare Advantage (MA) plans.)

In previous reports, the Commission has recommended:

- creating pressure for efficiency by restraining providers' annual payment updates;
- improving accuracy in Medicare's payment systems to ensure Medicare pays adequately and fairly across different types of services and providers (e.g., increasing payments to primary care–focused practitioners);
- using payment incentives to promote care coordination and increase accountability among health care providers (e.g., pay for performance, readmissions penalties, piloting bundled payments); and
- broadening information available to patients and providers to enable them to choose high-quality, high-value health care services.

New report: *Aligning Incentives in Medicare*

The Commission's latest report discusses three areas that Medicare should address: (1) the training of the nation's health care workforce, (2) the role of the beneficiary in a reformed health care delivery system, and (3) the Centers for Medicare and Medicaid Services' (CMS's) ability to use value-based payment policies and to test and adopt innovative payment and delivery mechanisms.

We acknowledge that some of the topics raised in the Commission's June report were addressed at least in part by recent legislation. This overlap occurred because the Commission set its agenda for the year when the outcome and timing of the laws' enactment was not known.

Graduate medical education financing: Focusing on educational priorities

Despite the tremendous advances our graduate medical education (GME) system has brought to modern health care, the Commission finds that it is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. Two specific areas of

concern are education and training in skills needed to improve the value of our health care delivery system—including evidence-based medicine, team-based care, care coordination, and shared decision making—and workforce mix—including trends in specialization and limited socioeconomic diversity.

We cannot accomplish delivery system reform without simultaneously ensuring that the providers we need have the skills necessary to integrate care across settings, improve quality, and use resources efficiently. In a recent *New England Journal of Medicine* article, prominent physicians assert that not only do residents need to learn relatively new skills, they need to develop a new perspective on what it means to be a "good doctor"—shifting emphasis, for example, from independent and autonomous practice to more patient-centered, team-based care.

The GME system is influenced not only by how Medicare subsidizes GME but also by how Medicare and other insurers pay for health care services. FFS payment systems reward volume without regard to quality, and the levels of payment for physician services tend to reward performing procedures over patient evaluation, management, and care coordination. These payment signals affect not only physician career choices but also institutional decisions about which residency programs to offer.

In *Aligning Incentives in Medicare*, the Commission makes five recommendations to the Congress to address these challenges. The recommendations rest on two principles: decoupling Medicare payments for GME from Medicare's FFS payment systems and ensuring that resources for GME are devoted to meeting educational standards.

First, the Commission recommends decoupling a significant portion of Medicare's GME payments from FFS payments to inpatient hospitals and making the payments contingent on reaching desired educational outcomes and standards. Under this recommendation, the Secretary of Health and Human Services would consult with organizations and individuals with the necessary expertise and perspectives to establish the desired standards—specifically, representatives from organizations such as program-accrediting bodies, certifying boards, training programs, health care organizations, health care purchasers, and patient and consumer groups. From these deliberations, the Secretary would develop a GME payment system that

fosters greater accountability for Medicare's dollars and rewards education and training that improves the value of our health care delivery system. To allow adequate time for development of rigorous educational standards and criteria, Medicare's new, more accountable payment approach should begin in three years, in October 2013. Funding for this initiative should come from the amount that Medicare is currently paying hospitals above their empirically justified costs for indirect medical education—currently estimated to be $3.5 billion. Savings from this reduction should be used to fund incentive payments to institutions (such as teaching hospitals, medical schools, and other eligible entities that may sponsor residency programs) that meet educational standards. The Commission stressed that only those institutions meeting the criteria would be eligible for incentive payments. Conceivably, therefore, all, some, or none of this amount could be distributed. Distribution of payments would depend on program and institutional performance.

The Commission's second recommendation—to make information about Medicare's payments and teaching costs publicly available—also fosters greater accountability for educational activities within the GME community. During the Commission's examination of GME financing issues, some residency program directors voiced concerns that they have difficulty gaining information about their teaching hospitals' GME revenues because the GME payments go directly to the hospital. Consequently, it can be challenging for them to judge whether Medicare's GME payments are being distributed appropriately and equitably. This recommendation is designed to encourage collaboration between educators and institutions on residency program funding decisions. Although interpreting reported cost data may require some caveats, the transparency of this payment and cost information will recognize Medicare's significant investment in residency (and some nursing) training and education.

The final three recommendations call for studies to examine specific aspects of health workforce training. Currently, Medicare's payments for GME generally subsidize the specialty choices of both teaching hospitals (in their program offerings) and residents (in their career choices). The resulting physician mix of specialties is unlikely to ensure that the nation has an adequate supply of health professionals for well-functioning delivery systems, as evidenced by falling shares of physicians practicing primary care after their residencies.

The Commission recommends that a rigorous, independent analysis of our health care workforce needs be conducted on an ongoing basis. This analysis should be driven by the requirements of a high-value, affordable health care delivery system. Analyses that simply extrapolate demand projections based on current patterns of care compromise the nation's chances of fostering high-value health care systems. An improved delivery system will influence the total number of physicians and the mix of professionals needed in our health workforce. Consequently, any decisions about Medicare's funding of new residency positions should await the results of such a study.

Second, the Commission is interested in the net impact that residency programs of different specialties have on their hospitals' financial performance. Some residency programs may improve hospitals' financial performance, while other residency programs may not. For example, some specialties may require greater supervision costs, while others may attract higher volumes of more profitable services to the institution. Also in question is the optimal level of Medicare GME payments by resident specialty type. There is little research on these differences. A better understanding of these financial impacts could inform a more efficient distribution of GME dollars among residency programs. Therefore, the Commission recommends a specialty-specific analysis of net institutional costs and benefits.

A third workforce goal that deserves concerted attention is to find the most effective strategies for increasing the diversity of our pipeline of health professionals (i.e., increasing the share of professionals from underrepresented racial and ethnic minorities, from lower income families, and from rural hometowns). Research has found that a diverse health care workforce is associated with better care quality and access for disadvantaged populations, greater patient choice and satisfaction, and better educational experience for students in health professions. A number of programs, administered by the Health Resources and Services Administration, are designed to address this goal. While research on several specific programs shows some positive impact on health care workforce diversity, comprehensive evaluation of these programs' longitudinal effectiveness is not well studied. Therefore, in order to optimize federal subsidies for this category of programs, the Commission recommends a study that outlines a strategy for achieving health care workforce-diversity goals.

Beneficiaries' role in delivery reform

Benefit design. Reforming the design of the traditional Medicare FFS benefit offers an opportunity to align beneficiary incentives with the goal of obtaining high-quality care for the best value. Of particular importance, reforms could also improve financial protection for individuals who have the greatest need for services and currently face very high cost sharing.

The current FFS benefit design has several challenges with respect to beneficiary out-of-pocket expenses. There is no upper limit on the amount of Medicare cost-sharing expenses a beneficiary could incur, exposing Medicare beneficiaries to substantial financial risk and potentially discouraging the use of valuable care. In addition, a beneficiary's out-of-pocket expenses during the course of a year can be unpredictable and highly variable. As a result, more than 90 percent of Medicare beneficiaries have supplemental coverage through former employers or medigap policies, or they have additional coverage through Medicare Advantage plans, Medicaid, and other sources.

The most widely used types of supplemental coverage, such as standard medigap Plan C and Plan F policies, fill in all or nearly all of Medicare's cost sharing in return for a monthly premium. Although popular, some forms of secondary insurance are expensive, with administrative costs of 20 percent or more. Supplemental coverage addresses beneficiaries' concerns about the uncertainty of what cost sharing they might owe in the FFS Medicare benefit, but it also dampens financial incentives beneficiaries would otherwise face to control spending.[2] There is a similar dynamic in the MA program, in which high payments to plans (relative to FFS) enable insurers to offer zero-premium plans and extra benefits to beneficiaries. Since these features are subsidized through high payments, which mask the real costs of the benefits, they are not accurate price signals to the beneficiaries. In the current MA program, the beneficiary does not have a financial incentive to choose a high-quality, efficient plan.

Commission-sponsored work shows evidence that when elderly beneficiaries are insured against Medicare's cost-sharing requirements, they use more care and Medicare spends more on them.

[2] Recent legislation directs the National Association of Insurance Commissioners to revise standards for the most popular supplemental plans to include requirements for nominal cost sharing to encourage the use of appropriate physician services under Part B. New standards are due to be in place by January 1, 2015.

However, this higher spending often does not result in better health or improved outcomes and could reflect spending on low-quality health care. Under the current FFS payment systems neither the program nor beneficiaries can easily discriminate high- from low-value care. A body of health services research literature finds that cost sharing can have either beneficial or detrimental effects on beneficiaries' health outcomes, depending on how it is structured. Encouraging use of high-value care and discouraging use of low-value care are the great challenges of benefit design.

For the near term, potential incremental improvements to the FFS benefit and to supplemental coverage could begin changing beneficiaries' incentives. The aim of these improvements would be to reduce financial risk for beneficiaries with the highest levels of cost sharing, deter beneficiaries' use of lower value services, and avoid deterring beneficiaries from using higher value care—especially individuals with lower incomes. Potential improvements could include, for example, adding a cap to beneficiaries' out-of-pocket (OOP) costs in the FFS benefit and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use. Such restrictions on supplemental coverage could lead to reductions in use of Medicare services sufficient to help finance the addition of an OOP cap. These strategies could be coupled with exceptions that waive cost sharing for services in certain circumstances—for example, if evidence identified them as leading to better health outcomes. The strategies could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care. Providing beneficiaries with clear information to help them consider their treatment options with their providers could also be complementary to changes in benefit design.

In the longer term, changes could involve developing the evidence base to better understand which treatments are of higher and lower value. As currently practiced, certain insurance designs attempt to encourage use of high-value care by lowering cost sharing for services that have strong evidence of substantial clinical benefit. A primary goal of this approach is to improve quality and possibly lower costs by avoiding the need for more expensive care in the future. However, to also ensure net savings, this approach requires careful targeting and

willingness to both lower cost sharing for services of high value and raise cost sharing for services of low value.

Shared decision making. Medicare beneficiaries face certain challenges when making decisions about the relative value of different health care services. Although they are insured, Medicare beneficiaries, on average, are more likely to be poorer, less educated, cognitively impaired, faced with multiple chronic conditions, and less health literate than other consumers. All these factors may increase their difficulty understanding the information they receive about their health conditions and the risks and benefits posed by different treatments. In an effort to mitigate these problems and to make care more patient-centered, some clinicians have adopted a model of shared decision making.

Shared decision making is the process by which a health care provider communicates personalized information to patients about the outcomes, probabilities, and uncertainties of available treatment options, and patients communicate their values and the relative importance they place on benefits and harms. It is a way to facilitate patient participation in decision making. Information is conveyed through patient decision aids that provide patients with evidence-based, objective information on all treatment options for a given condition.

Physicians, not patients, have the expertise to know which approach to surgery is best, for example, or the side effect profile of different medications, but only patients know what their feelings are toward particular risks and benefits. When the patient understands the risks and the physician understands the patient's concerns, the physician is better able to recommend a treatment that will address the medical problem and respect the patient's values. To date, shared decision making has been used more widely by specialists than primary care doctors because specialists are more likely to interact with patients around treatment options with more latitude for discrete decision making, like cancer treatment and back surgery.

Medicare could promote the use of shared decision making in a number of different ways: design a demonstration project to test the use of shared decision making for Medicare beneficiaries, provide incentives to practitioners who adopt shared decision making, provide incentives to

patients who engage in shared decision making, or require providers to use shared decision making for some preference-sensitive services.

Enhancing Medicare's ability to innovate

Innovative purchasing policies could be employed to improve the delivery of health care services, but Medicare currently has legislative limits that constrain it from adopting such policies expeditiously. Furthermore, Medicare might be able to improve health care quality and efficiency if it were given broader authority to demonstrate and implement policy innovations.

Purchasing policies. Medicare has attempted to use several innovative policies that have the potential to increase the value of the program for beneficiaries and taxpayers, but their application has been limited by lack of clear legal authority. Reference pricing, performance-based risk-sharing strategies, and coverage with evidence development (CED) are three examples. The three policies have the potential to improve payment accuracy and decrease knowledge gaps. In addition, they complement the recent federal investment in comparative-effectiveness research. Reference pricing and performance-based risk-sharing strategies use such information in establishing payment for a service or product. Coverage with evidence development focuses on collecting real-world clinical evidence that patients, providers, and policymakers need to reach better decisions about a service's or product's effectiveness. Medicare's use of each strategy has been hampered because the program's legal foundation is uncertain or lacking.

Some statutory limits even prevent Medicare from making technical changes to its current payment systems. For example, updating case mix and wage indexes in prospective payment systems would improve payment accuracy, but Medicare often lacks the authority to do so, even when the change is budget neutral. Similarly, a change in law is also necessary for Medicare to implement policies that pay providers based on their quality. Medicare needs clear authority to make such changes in its current payment systems.

Research and demonstrations. The Medicare program has used research and demonstrations for decades to test the conceptual and operational feasibility of new payment policies and health care

service delivery models. Over the last several years, the Commission and other observers have noted a growing disconnect between Medicare's urgent need to implement payment and service delivery innovations and the program's limited ability to research, test, and evaluate demonstrations that provide the information policymakers need to implement effective policy changes program wide.

The Commission most recently expressed its concerns about the pace of Medicare's demonstrations in a mandated report to the Congress on improving Medicare chronic care demonstration programs. Its analysis of four recent Medicare demonstrations suggested several larger issues with the structure and funding of research and development in Medicare, including: very low levels of funding for research, demonstrations, and evaluations relative to the overall size of the program; constraints on CMS's ability to redeploy research and demonstration funding as the program's needs change; and the existence of time-consuming and resource-intensive administrative requirements in the executive branch demonstration review process. Commissioners also have raised concerns about the level of Medicare resources allocated for health services research activities, such as funding and staffing for intramural and extramural research projects and to revamp the agency's data infrastructure to provide policymakers with timely access to program and demonstration data.

In March, the Congress authorized the creation of a Center for Medicare and Medicaid Innovation (CMI) within CMS with the intention of improving CMS's research and demonstration programs. The CMI is charged with testing innovative payment and service delivery models and can operate without many of the constraints currently imposed on CMS' research programs. For example, the law waives the requirement to demonstrate budget neutrality when a model is in initial testing phases, and exempts Paperwork Reduction Act review. The law also provides for $10 billion in annual appropriations for activities initiated in 2011 to 2019. As this new approach to innovation is being implemented, there are several lingering issues that will need to be monitored. First, there will be an inherent tension between the speed of innovation and the quality of the evidence used to evaluate the new methods. In other words, obtaining the type of evidence that might be produced in an academic model of program evaluation may not be attainable in a dynamic, forward-looking innovation process.

Second, CMS will need sufficient administrative resources to effectively operationalize new payment methods, since the agency will likely be overseeing multiple models of new payment methods while continuing to maintain the current fee-for-service payment system for those providers who do not volunteer to participate in the CMI activities.

Additional topics addressed in MedPAC's June report

The report also includes four additional chapters that touch on payment accuracy and moving away from the volume incentives in FFS Medicare and highlight more systemic changes to better align provider incentives with a reformed delivery system.

Medicare's role in supporting and motivating quality improvement

There is wide variation in the quality of health care in the United States, and the pace of quality improvement has been frustratingly slow. The Commission has recommended payment incentives and public reporting to motivate better quality, but they may not be sufficient to induce the magnitude of quality improvement needed. In *Aligning Incentives in Medicare*, the Commission looks at two additional ways to motivate quality improvement: offering technical assistance to providers and reforming conditions of participation.

Some providers may need technical assistance in improving care. This assistance could be particularly helpful when improvement requires coordination among many providers during a patient's episode of care, management of a highly complex organization, or coping with the challenges of serving a rural or a low-income population. One source of technical assistance is Medicare's Quality Improvement Organization (QIO) program, but the performance of the QIO program has been variable and its benefits have been difficult to demonstrate. In addition to the QIOs, there may be advantages to allowing other entities (e.g., high-performing providers, professional associations, consulting organizations) to participate as technical assistance agents serving low performers. For example, under an alternative quality improvement model, low performers could choose which entity would be best suited to provide them Medicare-supported technical assistance.

Another way Medicare can stimulate quality improvement is by revisiting its conditions of participation (COPs)—the minimum standards that certain provider types are required to meet to participate in Medicare. Providers, state governments, and the federal government collectively spend millions of dollars annually preparing for and conducting surveys to ensure compliance with these standards, yet it is unclear how much these efforts have accelerated the pace of change. Various options exist that could reenergize the survey and accreditation process, including updating the COPs to align them with current quality improvement efforts, imposing intermediate sanctions for underperformers, creating higher standards that providers could comply with voluntarily to be designated publicly as a high performer, and using performance on outcomes measures (e.g., mortality rates) as a criterion for providers to be eligible to perform certain procedures.

Modifying the COPs in tandem with providing targeted technical assistance may introduce a new balance of incentives that could accelerate quality improvement and make health care safer for Medicare beneficiaries.

Coordinating the care of dual-eligible beneficiaries

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) are, on average, more costly for the program than other beneficiaries. In addition, the Commission finds that among dual-eligible beneficiaries are distinct groups with widely different care needs and spending patterns. Dual-eligible beneficiaries account for disproportionate shares of both Medicare and Medicaid spending relative to their enrollment, and yet neither program assumes full responsibility for coordinating all of their care.

The Medicare and Medicaid programs often work at cross-purposes in coordinating care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise total federal spending and lower quality. Conflicting incentives can also encourage providers to seek out higher payment rates, such as hospitalizing a long-term care resident in order to qualify for Medicare's skilled nursing facility payments.

Improving the care for dual-eligible beneficiaries requires two fundamental changes: First, the financing streams need to be more integrated to dampen current conflicting incentives that undermine care coordination; second, an integrated approach to care delivery is needed to ensure quality care for this complex population. Entities that furnish integrated care need to be evaluated using outcome measures such as risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, and emergency room use. In addition, condition-specific quality measures and measures that reflect the level and success of care integration need to be gathered so that the success of care integration for different subgroups of duals can be assessed.

Two approaches currently in use—the Program of All-Inclusive Care for the Elderly and managed care programs that contract with states for Medicaid and with Medicare as Medicare Advantage special needs plans—offer more fully integrated care. These programs combine funding streams so that the conflicting incentives of Medicare and Medicaid are mitigated. Entities are also at risk for all (or most) services, including long-term care, and provide care management services. Mixing Medicare and Medicaid dollars can create the opportunity for states to cost shift to Medicare. If arrangements are contemplated that provide funding for both Medicare and Medicaid services to the states, special attention to enforcement would be required to ensure state programs maintain levels of effort and beneficiary access, and fund the intended services.

While integrated approaches have the potential to succeed, they are few in number and enrollment in some programs is low. Numerous challenges inhibit expanding their numbers and enrollment. Challenges include the lack of experience managing long-term care, stakeholder (beneficiaries, their advocates, and providers) resistance, the initial program investments and financial viability, and the separate Medicare and Medicaid administrative rules and procedures. Also, by statute, Medicare beneficiaries must have the freedom to choose their providers and cannot be required to enroll in integrated care. However, several states have implemented fully integrated care programs, illustrating that it is possible to address these obstacles.

Addressing the growth of ancillary services in physician offices

Many physicians have expanded their practices in recent years to provide ancillary services, and these services have experienced rapid volume growth over the last five years. Rapid volume growth, along with the diffusion of new technologies to broad populations, raises questions about the equity and accuracy of physician payments. Moreover, there is evidence that some diagnostic imaging and physical therapy services ordered by physicians may not be clinically appropriate.

The Ethics in Patient Referrals Act, also known as the Stark law, prohibits physicians from referring Medicare patients for "designated health services" (DHS)—such as imaging, radiation therapy, home health, clinical laboratory tests, and physical therapy—to entities with which they have a financial relationship, unless the relationship fits within an exception. The in-office ancillary services (IOAS) exception allows physicians to provide most DHS to patients in their offices.

On the one hand, proponents of the IOAS exception argue that it enables physicians to make rapid diagnoses and initiate treatment during a patient's office visit, improves care coordination, and encourages patients to comply with their physicians' diagnostic and treatment recommendations. On the other hand, there is evidence that physician investment in ancillary services leads to higher volume through greater overall capacity and financial incentives for physicians to order additional services. In addition, there are concerns that physician ownership could skew clinical decisions—incenting physicians to provide certain tests or treatments that their clinical judgment would not otherwise lead them to order if they did not have a financial stake in the equipment.

To examine the frequency with which services covered by the IOAS exception are provided on the same day as an office visit, the Commission analyzed Medicare claims data. This analysis shows that outpatient therapy (such as physical and occupational therapy) is rarely provided on the same day as a related office visit. In addition, half or fewer than half of imaging, clinical laboratory, and pathology services are performed on the same day as an office visit. The finding that many ancillary services are not usually provided during a patient's office visit raises

questions about one of the key rationales for the IOAS exception—that it enables physicians to provide ancillary services during a patient's visit.

Under Medicare's current FFS payment systems, which reward higher volume, physician self-referral of ancillary services creates incentives to provide more services. Under a different model, however, in which providers received a fixed payment amount for a group of beneficiaries (capitation) or an episode of care (bundling), they could still self-refer, but would not be able to generate additional revenue by ordering more services. Therefore, the preferred approach to address self-referral is to develop payment systems that reward providers for constraining volume growth while improving the quality of care. Because it will take several years to establish new payment models and delivery systems, policymakers may wish to consider interim approaches to address concerns raised by the growth of ancillary services in physicians' offices. The Commission had not yet made recommendations, but it does explore the pros and cons of several options in more detail:

- excluding therapeutic services such as physical therapy and radiation therapy from the IOAS exception,
- excluding diagnostic tests that are not usually provided during an office visit from the exception,
- limiting the exception to physician practices that are clinically integrated,
- reducing payment rates for diagnostic tests performed under the exception,
- improving payment accuracy and creating bundled payments, and
- adopting a carefully targeted prior authorization program for imaging services.

Inpatient psychiatric care in Medicare: Trends and issues

Medicare beneficiaries with mental illnesses or alcohol- and drug-related problems who are considered a risk to themselves or others may be treated in inpatient psychiatric facilities (IPFs). To qualify as an IPF for Medicare payment, a facility must meet Medicare's general requirements for acute care hospitals and must be primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons. In 2008, Medicare spent $3.9 billion on IPF care. About 295,000 beneficiaries had almost 443,000 stays. Unlike in other settings, most Medicare beneficiaries treated in IPFs qualify for Medicare because of a disability.

As a result, IPF patients tend to be younger and poorer than the typical beneficiary. A majority (56 percent) of IPF patients are dually eligible for Medicare and Medicaid.

The Commission identified several characteristics of the IPF sector that raise questions about payment accuracy in the IPF PPS. Almost three-quarters of IPF discharges are diagnosed with psychosis and thus receive the same base payment under the prospective payment system. However, research has shown that within the category of psychosis, patients generally had either schizophrenia or a mood disorder—the costs of which may differ significantly. In addition, some patient characteristics that may substantially increase the cost of caring for an individual in an inpatient psychiatric setting, such as deficits in activities of daily living and suicidal and assaultive tendencies, are not recognized by the IPF payment system.

An important variable in assessing provider costs is the quality of care provided. Unfortunately, the development of outcomes measures for IPFs has lagged behind that for nonpsychiatric medical care. Ultimately, improving the quality of care furnished to beneficiaries with serious mental illnesses will necessitate looking beyond the IPF stay to ensure that patients receive adequate and appropriate outpatient mental health services. Such services can reduce severity of illness and improve beneficiaries' productivity and quality of life.

Conclusion

With this report, we present to you a number of opportunities and challenges for the Medicare program. The Commission believes these issues are important for ensuring access to high-quality care for current Medicare beneficiaries as well as sustainability of the program, to protect it for beneficiaries in the future. We appreciate the opportunity to discuss our report with you and look forward to your questions.

Mr. PALLONE. Thank you, and we are going to have questions, obviously, and I will start with my questions.

I want to focus on the GMEs. I am concerned about the fact that we are apparently suggesting taking some of the existing funding and redirecting it based on the standards of performance, and I am worried about placing further financial strain on safety net hospitals, some of which I represent. Many of them already called me about this proposal.

And also I am not really sure now, again I haven't read the report in all its detail, but you know, what is the significance of this empirically justified amount? In other words, what you are saying is, if it is above the empirically justified amount, then that is the money that would be redirected.

Mr. HACKBARTH. Yes.

Mr. PALLONE. What is that criteria, empirically justified amount?

Mr. HACKBARTH. OK. Medicare pays roughly $9.5 billion for graduate medical education each year, and it basically is broken into three relatively equal parts. The first is what we refer to as the direct medical education payments. Those dollars pay for resident salaries, faculty salaries, direct expenses of that sort. The other two pieces are paid with the indirect medical education adjustment.

Teaching hospitals receive a percentage add on to each payment they get for a Medicare admission based on a formula that includes the resident-to-bed ratio. When Congress enacted that adjustment back in 1983, it asked for an analysis of how much costs increased to hospital due to teaching activity. And that amount was calculated.

Congress basically doubled that amount. So we refer to the actual increased cost—increased cost in hospital care is the empirical amount and then the additional doubling of it as the extra IME.

Mr. PALLONE. You see the problem that I have is, you know, one could argue that all of this is very artificial and that we should have a totally different method of financing graduate medical education. We could have a series of hearings on that, and maybe we should. But the problem is the reality. The reality is that these hospitals are depending on this money, and it may be somewhat of an artificial formula, but at this time, if you are just going to say, OK, we are going to take some of the money away, I just think, I am concerned that this is not the right time to do that. We can argue about how this formula was set up. But right now, at this time, given the recession, given all the things that we face out there, why does the commission feel that this is a wise step right now?

Mr. HACKBARTH. Well, we are, I would like to emphasize that we are not saying, take the money away.

Mr. PALLONE. But isn't that, in effect, what will be happening?

Mr. HACKBARTH. What we are saying is, establish accountability for the use of the funds. Let's make sure that——

Mr. PALLONE. But my point, Doctor, is that, you know, we get to the point where the way we have gotten to this formula now, you can argue how we got there or not, but you have to be concerned, or at least I think I do and I think many of my colleagues, about the consequences of it. And I am just concerned that—I want

you to be innovative and come up with new ideas, and many of your ideas we have incorporated in the health care reform. I am not suggesting otherwise. It just seems right now if the consequence of this is that money is taken away from some of these hospitals that are barely, that are in the red, have you taken that into account?

Mr. HACKBARTH. We have. And what we have proposed is that the new standards would take effect 3 years from now so there would be a 3-year period to develop the standards that would guide the new payment policy and to give the institutions an opportunity to prepare to adhere to those standards.

Mr. PALLONE. I think I am going to stop because I have additional questions. I am sure my other colleagues are going to delve into this GME thing more.

Let me just ask about the diagnostic tests. In your report, you explore the suggestion that reducing payment rates for diagnostic tests performed under the in-office ancillary exemption would help to slow growth for these services.

But I wanted to ask you, beyond the 2006 and 2008 data you examined, to what extent did you take into account the cuts that have occurred in the recent past, for instance the impact of the Deficit Reduction Act, the reductions in payments due to January 1, 2010, changes in the physician fee schedule?

The concern I have is the rates for these services, particularly advanced imaging, have declined significantly in recent years. And so, again, I am again hearing from them about how this is going to be a problem because of all the cuts we already had.

Mr. HACKBARTH. What we propose is a series of very targeted reductions in payment for imaging. And we have taken into account the effect of those. And we think that the payments would continue to be adequate to assure reasonable access.

What we have right now is very rapid growth in high end imaging and a lot of people investing equipment, and once it is in the office using it at a high rate. And to us that signals that the payments have been quite generous in the past. And what we need to do is bring the payments more in line with the cost of that care, and then we have recommended redirect those funds to other higher value uses for the Medicare program.

Mr. PALLONE. OK. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman, and Mr. Hackbarth, I apologize for you getting involved in the health care law food fight, but we only get the opportunity to openly discuss this, and I think it does call for a hearing. That is all we are saying. That is our point. If they are right, let's have a hearing; if we are right let's have a hearing. And there are problems that in this law we know that need to be fixed. They are smaller ones, but, so we just take the opportunity, the limited opportunity we have to address our concerns.

In response to the chairman, we did pass a bipartisan bill called the food safety bill. It passed out of here on a voice vote I think and passed on the floor, and we were involved in that and when we are asked to work together, I think we can do so effectively.

The health care bill creates a $1 trillion new cost. And I am just going to ask on this $500 billion, $500 billion wasn't all the Medicare Advantage, as you know; $20 billion was revision to the Medicare Improvement Fund, which is to help doctors continue to take Medicare patients, $20 billion over 5 years; $156 billion came from ensuring Medicare sustainability, revision in the Market Basket Updates, which is payments to hospitals; $156 billion out of 5 years on this new law; payment adjustments for home health, $40 billion.

So, I would caution my colleagues that there is $135 billion on the Medicare Advantage. That is something they did mention. But I would question to make sure we do a total of the entire $500 billion in cuts because some of it is to hospitals; some of it is to individuals, and that is what this law did.

I look at the, trying to find the mission statement, and under the front cover says, Medicare, you are supposed to help us on the Medicare Advantage program, providers in the Medicare traditional fee-for-service, and analyze care, quality of care, and other issues affecting Medicare. And you do. But I think for macro versus micro, you have gone into a lot of the micro aspects, and you have done it for a long time and, again, well respected and been around for a long time. We are worried about some of the macro issues, too, and I know, because implementation takes time, it is tough to check the implications of the new law, especially in this report, but I think that is an important aspect to look at, especially when you have the, whether they like it or not, $500 billion of cuts, and it is not all coming from Medicare Advantage. It is coming from hospitals. It is coming from physicians. There are tax increases that are going to effect service.

Having said that, are the people on the committee, I was going through the bios, are there any economists on here?

Mr. HACKBARTH. Yes, there are.

Mr. SHIMKUS. And the physicians are for-profit, not-for-profit, the hospital administrators from both for-profit hospitals and not-for-profits hospitals?

Mr. HACKBARTH. Currently not-for-profit.

Mr. SHIMKUS. Not-for-profit. No for-profit hospitals?

Mr. HACKBARTH. No for-profit hospitals, no.

Mr. SHIMKUS. Is there a reason, do we know?

Mr. HACKBARTH. Well, as I say, the GAO does the appointments. So we don't select our own members. And so I don't know the answer to that question. I wouldn't expect that we would never have a for-profit. We just currently don't have for-profit.

Mr. SHIMKUS. I am a market-based capitalist, conservative. I believe in supply and demand. I believe individual consumers, given the ability to access information, will drive prices. You will get higher quality and lower cost. I am concerned about third-party payers, and institutions, in essence, try to set fees. When an individual consumer is given the information and the access probably is a better system.

The GME issue is just one sliver of what you are doing, but I understand it is a very important aspect to you. We have hospitals that have too many GME slots. We have places in this country with not enough slots. And in the moving of the—I want more slots is what I want. Is there, in the calculation of the payments, is the

payment, say for a GME slot in New York City, is the payment the same as it would be in Springfield, Illinois, for a teaching hospital? Or is there a cost of where the education is going? Is there a percentage ratio there?

Mr. HACKBARTH. Well, we have got, as I said to Chairman Pallone, we have got two different types of GME payments. We have got the direct payments for salaries and the like, and then we have the indirect add-on. The direct payments are set at a hospital specific amount. So there is a base year, based on the actual costs incurred for salaries and direct expenses in that year, and then that has been inflated by the CPI since.

The indirect piece is a percentage add-on to whatever they get paid for Medicare admission. So that does reflect different wage indices and different costs of care.

Mr. SHIMKUS. So I will end on this, and I appreciate the chairman's permission to just finish with the statement. We need more, in this environment, with doctors talking about leaving the profession, we need more doctors. We need more GME slots. And I believe in supply and demand, and the higher supply you have, the lower; more supply you have, the lower cost, but we have got to get them out. And they have got to get trained in educational institutions.

Mr. HACKBARTH. Chairman Pallone.

Mr. PALLONE. Yes, please respond.

Mr. HACKBARTH. May I make a brief comment about the number of slots? It may well be true that we need more slots, more physicians being trained. That is not an issue that we have looked specifically at. There are certainly a lot of people who believe that.

What we have said, though, is that before Medicare decides to fund more slots, we think we would do well to step back and do a careful assessment of what our long-term needs are likely to be. We shouldn't just extrapolate from the past, but look at the mix of physicians and other health professionals that we will need for a more efficient system in the future and then base our decisions about GME funding on that analysis.

Mr. SHIMKUS. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you very much.

And I want to stay on this topic. I think you are generally on the right track when it comes to the GME, to say we have got to look at these trends and specialization. I can't tell you how many young residents or med students I meet, med students who are gung ho; they are going into family practice or general practice or pediatrics. And then I see them a few years later, and their loans have taken the toll, and they are going to go into plastic surgery or some other specialization. And so I think it is very wise to plan ahead and begin to look at how we create those incentives. So I appreciate that very much.

And the diversity mix, MedPAC has done a good job focusing in on kind of the lack of how the medical field oftentimes does not reflect our population. We need to improve that because that means better care, although women now are going gangbusters in our colleges of medicine.

I had really hoped that MedPAC would also address this issue of the static nature of the cap and what that has done to States that have grown in population since 1996 when that cap was put on because it has created such a harmful dynamic in my State that has been a high-growth State in other areas.

We have got three major GME-related issues. One, our resident-to-population ratio is in very bad shape. Two, we don't have nearly enough slots to account for all of our medical school graduates. We have nine med schools, but at least two-thirds of all students leave the State to practice.

And then we have hospitals operating above their caps. They are struggling to pay for those additional residents and fear that they may not be able to keep up with those extra, the extra costs that those slots require.

So, in the big picture, we can generally say that more slots doesn't necessarily ensure better care or overall better training, as asserted in your report. However, there is this other issue that I know we, in our health care reform law, we said we are going to do a workforce study. And you mentioned that here, and in fact, Secretary Sebelius announced new residency positions just this past week for primary care, so that is very positive.

Could you please address, why didn't MedPAC consider the geographical inequities here in this report that are so fundamental? It is really underlying the workforce issue and the diversity issue.

Can you address that and the impact of cutting the limited GME funds that some States already receive?

Mr. HACKBARTH. We did not make specific recommendations about either increasing the caps or reallocation of them.

However, we did suggest that we needed to take steps; Medicare needs to take steps to increase the diversity of the physician workforce of the future in and make sure that we are bringing into medicine people who are inclined to practice in rural areas, practice in inner cities that may be underserved. Recent research shows that an important element in that decision where to practice is where the student comes from to begin with. And so there are programs in the public health service, authorized by this committee, that are targeted at trying to change the mix of physicians being trained, increase the diversity, we think those programs that directionally make a lot of sense.

Again, on the specific issue of how many physicians Medicare ought to support, we didn't look at that issue specifically just for a matter of time and resources, but we do think that it needs to be guided, a decision needs to be guided by careful analysis of future needs, whether they be geographic, diversity, specialty. The beacon that we aim for is a high-performance delivery system. If we just doubled the number of physicians with the current specialty mix, we may well not make our problems better; we could end up making them worse. And so we need to think first before we increase the funding.

Ms. CASTOR. We have got to harmonize what was in the health care reform law that says States that have these low resident-to-population ratios are going to get a little bit of help. And I was hoping in your report you would reference that.

I know you mentioned in the report that you weren't sure when the law would be finalized. But there needs to be some harmonization of those.

And quickly, on the IME payments, many hospitals feel that redirecting the IME payments, since the needed level of IME funding is difficult to quantify, leaves them in a position to come up with dollars for indirect costs on their own, and for some States, that are looking at DSH payments changing over time and the fact that we may still be serving many folks in this country that show up in the ER but will not be covered in the health care bill; it is very troubling to see another challenge on the horizon.

So if MedPAC recommends that we not make decisions about Medicare funding for new residency positions until an independent analysis of our health care workforce is conducted, is it premature to recommend that IME funds be redirected before the study is concluded?

Mr. PALLONE. I am going to have to—I am sorry, Ms. Castor, I have been not paying enough attention to the time. You are like 1 minute, 20 seconds. Why don't we send that in writing?

Ms. CASTOR. Thank you, Mr. Chairman, because, you know, I care about that.

Mr. PALLONE. I know. I appreciate it. We will send that in writing.

The next is the gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Thank you, Mr. Chairman.

Mr. Hackbarth, physician reimbursements under Medicare were cut back 21 percent last Friday. Many physicians in my district have told me they will stop seeing Medicare seniors because of these cuts. And indeed, some in the more rural areas have said, well, they will just move to an urban setting where the Medicare case mix is not quite as high.

Today, this mitigation, which has passed the Senate, that bill is being delayed by Speaker Pelosi, the bill that would restore these cuts, the cuts that may mean our seniors have a Medicare card but no physician to accept them.

Given our current physician shortage and the access problems that Medicare seniors are currently encountering, do you believe that Speaker Pelosi's decision to allow these 21 percent cuts to go forward will make it harder for new Medicare seniors, especially those in rural areas, to find a physician who would be willing to take them?

Mr. HACKBARTH. Well, it is obviously not my place to comment on Speaker Pelosi's position.

But let me just describe our position on this.

Each year, we do a large survey of Medicare beneficiaries to ask them about their access to physician services. We survey about 4,000 Medicare beneficiaries each summer, and we survey a like number, roughly 4,000, of privately insured patients that are just under the Medicare eligibility age, so we have a reference point.

Our survey done last summer, the summer of 2009, found that generally Medicare beneficiaries have access as good as or even better than privately insured patients in the 50 to 64 age group.

The area of concern within that generally good picture is around primary care.

Part of the survey that we do is we ask Medicare beneficiaries who are looking for a new physician whether they have any problem in finding a new physician. That is the most vulnerable group.

And what we find is roughly one quarter of Medicare beneficiaries say they have difficulty finding a new primary care physician. Again, this was 2009.

The number for privately insured patients in 2009 was actually a little bit higher; a higher percentage of privately insured patients said they were having difficulty finding a new primary care physician.

The lesson that we draw from that is the country has a growing problem with access to primary care. It is not unique to Medicare. It is a broader systemic issue. So that was 2009.

We are in the process now of doing our 2010 survey. I don't know what those results will be.

I would say, though, that the uncertainty and even anxiety caused by the annual, now more frequently than annual, debate over SGR can only be undermining the confidence of physicians and patients in the Medicare program. And so I don't know what the new survey results will be, but we are concerned that the repeated threat of very large cuts could impede access.

Mr. GINGREY. Well, Chairman Hackbarth, I appreciate you bringing that information to the committee. That is extremely important. And if I understood you correctly in last year, 2009, before ObamaCare patient protection affordable care act, one-fourth of Medicare patients seeking new physicians had difficulty finding one. And now we are in the situation where fully 10 million people, Medicare patients on Medicare Advantage, that program is being cut; I think Mr. Shimkus said the number was $130 billion over 10 years, so maybe 6 or 8 million of those 10 million will lose their coverage under Medicare Advantage. And then you compound that problem with a 21 percent cut. So we have put to put a Band-Aid on it now, and so those many physicians are going to say, I am outta here. And then you are going to get this deluge of new patients trying to find a doctor to cover them under Medicare. I just hate to think what your numbers are going to show when you survey those 4,000 in June, July of 2010.

Mr. HACKBARTH. I just want to be very clear, because this is such an important issue, about what the 2009 survey results were.

So we said that the most problematic area was Medicare beneficiaries looking for a new primary care physician. So that represents about, the number of Medicare beneficiaries seeking a new physician is about 6 percent, and it is one-quarter of that 6 percent that report experiencing a problem.

Now we have got 45 million Medicare beneficiaries. So even if we are only talking 1.5 or 2 percent, we are talking 900,000 Medicare beneficiaries. That is a lot of people and reason for concern. But it does represent 2 percent of the Medicare population.

And it is also important to emphasize, again, that this is not unique to Medicare. The privately insured patients were also reporting problems in finding a new primary care physician.

Mr. GINGREY. Thank you for your indulgence, Mr. Chairman. I am a minute over, and I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from California, Ms. Eshoo.

Ms. ESHOO. That you, again, Mr. Chairman for having this hearing.

Chairman Hackbarth, I have two questions. The first one has to do with the report's inclusion of a proposal that some of the graduate medical education funding provided to hospitals by Medicare be made contingent on practice-based learning to encourage medical residents to spend more time in community health clinic settings. Now some teaching hospitals in my district and elsewhere don't have the emphasis on outreach with ambulatory care settings right now. What does the commission think the impact on the current GME system will be under this proposal?

And what is the commission advising the Congress relative to the transition in order to incorporate what you have discussed in the proposal?

And my second question is, on self-referral. Experts across the board, of course, agree that physicians self-referral, where doctors refer patients for medical services in which they have a financial interest, is a costly drain on the Medicare system. I agree with that. The report goes into quite a bit of detail to demonstrate that self-referral under the Stark Law ancillary services exemption continues to grow, but noticeably absent from the report are any concrete recommendations about how to address this.

So can you address it?

Mr. HACKBARTH. Yes.

Ms. ESHOO. Those are my two questions. Thank you.

Mr. HACKBARTH. Thank you.

First, on the nonhospital-based training, training in community practice, a few points there. First of all, that is particularly important for some specialties. Obviously——

Ms. ESHOO. I am not arguing whether it is important or not, but since you make the recommendation about it and there are many that have brought up GME in their opening statements and some in their questions, my question was, what is the impact and how are you going to—what are you—what is the commission recommending in terms of the transition in order to accomplish this?

Mr. HACKBARTH. Well, the first step is to remove some of the barriers. In the current Medicare rules, there are rules about how the time of residents is counted that impede people from doing nonhospital training. The teaching hospitals have asked for those rules to be changed. A number of those changes were included in the affordable care act. And so that is something that the teaching institutions themselves have asked for, take down one of the barriers.

The second step is to make sure that those opportunities for nonhospital training are good experiences, rich experiences, because that is the experience that primary care physicians, for example, need in particular. That is the environment where they will be practicing.

And one of the reasons that young physicians in training don't go into primary care is they have that experience, ambulatory experience, and it is not a good one. It is in a clinic that is not well managed. They don't have time to deal with their patients, and so they are turned off by primary care. Fixing that problem, as you

say, is not something that is going to happen overnight; finding new settings, rich settings for people to train in.

So we recognize that there will be a period of time.

Our recommendation, as I said earlier, is that the new standards wouldn't go into effect for 3 years. But if, on this particular issue, the Secretary were to decide, oh, even more than 3 years is required to allow ample ramp up, then we wouldn't object to that. But we do think we need to be moving in that direction.

Ms. ESHOO. Good. And on the self referral issue? The report really does go into quite a bit a detail. It is really short on any recommendations.

Mr. HACKBARTH. We lay out I think about a half dozen options that might be considered.

For example, limiting self-referral to services provided on the same day as the basic visit, packaging certain imaging services, for example, with the visit payment, subjecting some types of high-end expensive imaging to prior authorization. There are I think a half dozen different options there.

What we have done, each of those has pros and cons. And we have laid them out so that now we can get people outside MedPAC to react to those options, help us deepen our understanding of their implications, and we would expect next year, with that additional information, we will come back and look at those six options or maybe some new ones.

Ms. ESHOO. Will it take you a year for you to gather that information before you make the recommendation to Congress?

Mr. HACKBARTH. I don't know exactly when we will take it up in our fall schedule, but it will be in the fall. It wouldn't be next June.

Ms. ESHOO. I see. I thought you said it would take a year to get them.

Mr. HACKBARTH. Next annual cycle is what I am referring to.

Ms. ESHOO. Thank you very much for your work and your testimony.

Mr. PALLONE. Thank you, Ms. Eshoo.

The gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thanks, Mr. Chairman.

Again, Mr. Hackbarth, we are pleased to have you here. Let me just be sure I heard you correctly when you gave your statement because we heard some discussion from the dais about Medicare Advantage, and I thought I heard you say that we need a robust Medicare Advantage. And that is something I have heard before in some of the Commonwealth on things. We heard that from the head of Scott—the physician from Scott and White last January who also happened to be a head of the AMA who endorsed the health care bill but with the cuts to Medicare Advantage. So why the dichotomy here?

Mr. HACKBARTH. I am sorry——

Mr. BURGESS. We cut Medicare Advantage, and we said that is that was a good thing in the health care bill, but you are telling us we need Medicare Advantage.

Mr. HACKBARTH. Yes. If I could, I would like to refer back to something Mr. Shimkus said. I believe strongly in the market and market signals. And how much you pay for something influences the product that you get.

I believe very strongly that having the option of enrolling in a private plan is a good thing for Medicare beneficiaries. But if we set the price too high, we get private plans that are not properly focused on increasing value for Medicare beneficiaries. We make it too easy. And the evidence that I would cite for that is that when the prices went way up, when we vastly increased the benchmarks on Medicare Advantage, we got a huge influx of private fee-for-service plans which added very little value.

Mr. BURGESS. I do have to interrupt you there because some of the data we have heard and we never got in this committee because we never have had advantage, but some of the information that we have gotten, again from the Commonwealth Fund, that are not just bastions of conservative thought, that Medicare Advantage did hold the promise, they did the care coordination, the disease management, the ancillary providers, the electronic medical records; all the things you want your care system of the future to do, they were able to provide. So I heard it at a roundtable dealing with the Physician Group Practice Demonstration Project that if you don't have Medicare Advantage, we can't do these things that you have asked us to do. And we believe we are on the right track.

I am going to have to leave that in the interest of time because I have things I just have to ask you. Appendix A of your report suggests that in addition to the 21 percent cut that went into effect June 1st, there is an additional 6.1 percent that will be shaved off physician reimbursement based on your calculations that will kick in January 1st. Is that correct? So an aggregate cut from last month of 26 percent by January 1st.

Is there any way to prevent or to create the delink, you say that goes into effect, say there is nothing anyone can do to stop that, is there any way to delink private insurance reimbursement from what Medicare is reimbursing? Because as you know, many of the private contracts pay at a percentage of Medicare.

Mr. HACKBARTH. Well, it is often the case, as you say, Mr. Burgess that private insurers use the Medicare relative value system. But typically they will use their own conversion factor. So the actual price paid is not Medicare. In some cases, it could be higher; in some cases, it could be lower.

Mr. BURGESS. Correct. And in the interest of time, it is generally like 110 percent of Medicare. But you cut Medicare 26.1 percent, Blue Cross Blue Shield, that pays 110 percent of Medicare, guess what? They get a big windfall for their stockholders, and the doctors end up holding the bag on that. I do think that is something I would like to see your group look at.

Let me just talk about a couple of things because they are terribly important.

In the health care bill that passed, we got the creation of the Independent Payment Advisory Board will that render the Sustainable Growth Rate Formula obsolete or are the physicians perhaps facing the specter of both the SGR and cuts in the Independent Payment Advisory Board?

Mr. HACKBARTH. Well, my understanding of the legislation is that the targets established for the Independent Payment Advisory Board are separate from SGR.

Mr. BURGESS. So the answer is, yes, they could be hit with both?

Mr. HACKBARTH. Right. And the difference, of course, is that the Independent Payment targets are program-wide. They are not just focused on physicians.

Mr. BURGESS. Right. But, again, that is one of the things that I think needs to be looked at with a great deal more scrutiny because I am getting these questions, and I have got to believe that doctors who are looking down the road at what we have done to them are going to be taking this quite seriously, and you may find your numbers of people who can find a Medicare physician actually dropping off more significantly beyond what you anticipated.

The last thing, the chairman has such a quick gavel, you brought up on the prior authorization on imaging, why is it, and I hated prior authorization, I hated calling 1–800 to get a procedure approved, but why doesn't Medicare look at a little bit of that type of activity? It is always a pay and chase; you pay something, and then wonder if it was advisable to do so and then try to chase someone down. In the private world, you end up having to get everything preauthorized, which is a pain and sometimes overdone, but why not incorporate some of the lessons that have been learned in the private sector to hold down the cost in Medicare?

Mr. PALLONE. That has got to be the last question.

Mr. BURGESS. See, I told you he is quick with that gavel.

Mr. HACKBARTH. As you know, increasingly, prior authorization is used to for expensive imaging services. There are companies that specialize in that business, running those prior authorization programs.

And it is an option that we will look at.

Obviously, the concern is the intrusiveness of it, the hassle of it for physicians. But it is something that has some advantages, so I don't know where we will come down, but we will look at it.

Mr. PALLONE. Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

And again, thank you for being here, Dr. Hackbarth.

I had to step out when my colleague, Dr. Burgess, was speaking, but I just have to get this off my chest because I really think that MedPAC has the whole provider reimbursement issue backwards, and therefore, the remedies are not really directed as they should. And I just wondered if MedPAC has ever considered providers are paid so very low reimbursement that they just have to see more patients to be able to keep their lights on, pay their staff, keep their doors open, as well as take care of their families.

All of the remedies are based, seem to be based, on the assessment that fee-for-service is the source of the problem, but I really think that it is the low fees. Doctors are really forced into a position where they have to see more patients, and CMS has never really paid us to sit down and talk or listen to our patients.

So I just wanted to get that off my chest.

Mr. HACKBARTH. In fact, we would agree that there are some physicians who are paid too little and paid, being paid fee-for-service may not even be the best method for paying a primary care physician.

But on the other hand, we think that there are other physicians who may be paid too much.

And so, rather than saying, oh, we think all fees should be cut, our view is more nuanced. We think that there is plenty of money in the Medicare physician payment pool in the aggregate, but it needs to be redistributed to support a high value care, more for some, less for others.

Mrs. CHRISTENSEN. And as a primary care physician, I appreciate the fact that primary care is going to be given more attention and have perhaps some higher reimbursement, but I don't see that that should be at the expense of the specialists. When you need a specialist, the situation is generally critical, and they have a specialized, by definition, service to provide.

Mr. HACKBARTH. Before I started doing this job, I was a CEO of a 500 physician multispecialty group practice in Boston. And our physicians were all paid on the salary. We were largely at that point a prepaid group practice. But if you looked at the difference between a primary care physician and a cardiologist or some specialist within a group like mine or you do the same at Kaiser Permanente today, the range is much narrower than existing fee-for-service. Yes, the specialists get paid more, but it isn't the huge gap that exists in fee-for-service Medicare. And so what we are suggesting is not that specialists not be paid appropriately for their additional training and the like, but we do think that that gap needs to be smaller.

Mrs. CHRISTENSEN. Thank you.

Let me try to get one other question in, and my time is fast escaping.

When CMS institutes a least-costly-alternative policy or code-bundling determination, providers face a financial loss each time they prescribe a product that is not the least costly product subject to the LCA policy or a product that is more costly than the blended reimbursement rate under a code-bundling decision. To the extent that Congress grants CMS's explicit authority to institute LCA policies or expanded code-bundling authority for drugs or biologics, what safeguards does MedPAC recommend including in such authorities to ensure you that patient access to important therapies is appropriately preserved?

And what kind of clinical evidence should CMS be required to consider before instituting that policy or bundling determination?

And what exceptions should Congress include to make sure that patients can get Medicare coverage for the more costly products when they are medically necessary?

Mr. HACKBARTH. Yes. Well, the decisions in executing least-costly-alternative reference pricing options of that nature need to be informed by the best available clinical evidence. And the process needs to be a transparent one, whereby all interested parties have an opportunity to present their information to CMS. As we say in the report, we think in some areas like this, it would be good to give CMS and the Secretary more flexibility than they have under the current law to execute these policies. But that doesn't necessarily mean abdication by the Congress either.

You can imagine ways that the Congress would reserve the right to override particular policies and the like. So we would like to see the needle shifted some towards more discretion but only based on

evidence, transparency, and there could be some residual congressional control.

Mrs. CHRISTENSEN. I am over my time.

Thank you.

Mr. PALLONE. Thank you.

The gentleman from Kentucky, Mr. Whitfield, who has 8 minutes.

Mr. WHITFIELD. Thank you, Mr. Chairman.

And Mr. Hackbarth, thanks very much for being with us today. We appreciate your presence.

I am going to revisit this one issue that Dr. Burgess mentioned, and that is Medicare Advantage. I want to do so because there are 13,000 seniors on Medicare Advantage in my congressional district. And my understanding is that there will be $200 billion taken out of the Medicare Advantage program. And in your testimony, you talked about the need for a robust Medicare Advantage program. And it seems to me that taking $200 billion away is the exact opposite thing that we would need to do in order to have a robust Medicare Advantage program. And I would just like your comments on that, and I have not had the opportunity to read all of this report, but what do you say about that in this report, if anything?

Mr. HACKBARTH. Yes. For many years now, going back to 2001, MedPAC had recommended reducing the Medicare Advantage rates. We believed that reducing them would leave, still leave ample resources for a well run, high-value Medicare Advantage plan to do very well in serving the Medicare population.

I have been a senior executive in such a plan. I have run a medical group that has had a lot of Medicare. It was back then Medicare Plus Choice; this was pre-Medicare Advantage. But I know a little bit about such programs from the delivery side.

Just increasing the rates, as was done in a series of steps by the Congress, does not assure a robust Medicare Advantage plan. In fact, in crucial ways, it undermines it by allowing signaling to plans you can do very well while doing very little. And again, the evidence that that was occurring is, as the rates got very, very high relative to fee-for-service Medicare, we had a large influx of private fee-for-service plans that were adding very little, if any, value to the Medicare program but doing very well.

That was not in the interest of the Medicare Advantage program, to allow low-value performers to do very well.

If you reduce the rates, yes, you make it more difficult in the first instance, but it is also the spur to finding ways to do things better that is needed. That is what drives markets. It is that spur, that pressure to find new innovative ways to produce a high-value product.

That had gone out of the Medicare Advantage program due to overpayment.

And so there is a lot of waste in traditional Medicare. We fill books each year documenting the waste in traditional Medicare. An innovative private plan, well managed and really focused, can find ways to provide Medicare benefits, plus more, to the Medicare population for less money than fee-for-service Medicare. I believe that.

Mr. WHITFIELD. So it is your position that you can maintain a strong, viable Medicare Advantage program even though you take that much money out of it?

Mr. HACKBARTH. Initially, you are likely to see a reduction in the number of plans and a reduction in benefits, higher premiums, fewer enrollees.

That is the short term. The long term, though, is that it will begin to change the nature of the plans that participate, and I believe towards a higher value, more worthwhile option for Medicare beneficiaries.

Mr. WHITFIELD. And over the long term, would you guess that there would be more Medicare Advantage programs available?

Mr. HACKBARTH. More individual plans offered? Again, it is going to depend on what your time horizon is. The first couple years, I would expect that you will see fewer. The easy money is gone, and people will say, oh, the easy money is gone, I will move on to something else. But over time, I think that you could see those numbers start to increase again.

Mr. WHITFIELD. Also, I notice, on page 3 of the report in chapter 1, and I told you I hadn't read it, but I read the first page already. But it says in this report that you describe the least-costly-alternative policy as one way that CMS can apply the results of comparative effectiveness research in order to help contain Medicare spending.

And yet when we were having the debate on the health care reform legislation, many people, including the President, were stating in no uncertain terms that comparative effectiveness research is providing patients and doctors with the information they need to make the best medical decisions. And there was never any reference to being a mechanism for cutting costs. So this report basically does say that that is one of the purposes of it. And in your mind, is there any inconsistency there?

Mr. HACKBARTH. I won't try to represent what President Obama or anybody else said.

Let me say what I believe. I believe that it is in the interests of patients and physicians and the broader population to have more information about what works. That information, as it is developed, can be applied in many different ways. One would be to inform policies like least-costly-alternative. Another would be to build into shared decision-making programs where Medicare beneficiaries and other patients can be more actively engaged in making choices over their own health care. Still another way might be to identify potential areas to reward through pay-for-performance programs. Still another way might be to inform coverage decisions. There are a lot of different ways to use that information.

You add them all together, having better information is good for patients and good for physicians.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. WHITFIELD. Can I yield Dr. Burgess 30 seconds?

Mr. BURGESS. One follow-up question on the Medicare Advantage, you referenced Medicare Plus Choice. Far before my time here, but that kind of went away because it was underfunded, did it not?

Mr. HACKBARTH. The enrollment did increase. We went through a similar cycle——

Mr. BURGESS. The short answer to the question is yes.

Let me ask you something else before the small amount of time I have goes away. Wouldn't it have been better, if we stipulate that you are accurate about your statements about Medicare Advantage and there is more money going into Medicare Advantage than needs to go into it and if we have these additional dollars of Medicare, wouldn't it have been better use of those funds to keep them in Medicare and deal with the number one problem that is going to affect access for Medicare patients in the future and that is offsetting the cost of fixing the SGR formula?

Mr. HACKBARTH. How to allocate funds is really above my pay grade. Those are choices for the Congress to make.

Mr. BURGESS. We have a whole book here about allocating funds.

Mr. PALLONE. All right. We have to move on here.

Next is Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

I heard there were questions earlier on graduate medical education. In Congress, we call it GME. Because I want to make a point on it. I was a sponsor of the provision in the health care bill that on a residency training in our FUHCs because we have a great example in the Houston area of the Denver Harbor Clinic with an agreement with the Baylor College of Medicine. Greater accountability in GME isn't a bad idea, though, and we need to debate exactly how we are going to go about doing that because we don't want to hurt our hospitals or our resident programs, but we also like to make sure those physicians, those medical students know they can make a good living by practicing in FUHCs and hopefully will grow them.

Mr. Hackbarth, again, I want to thank you, like all the committee members, for your being here today and the report. Your testimony and the report discussed demonstration projects at CMS and certain hurdles that these projects face, including low levels of funds and constraints on CMS in conducting these demo projects. Can you discuss these issues? And I know many of us in Congress, I like having CMS conduct a demonstration before implementing a broad policy on everyone, simply because it is a test model, to see how it works and if it is successful. Can you just address that?

Mr. HACKBARTH. Yes. Well, as you well know, Mr. Green, the health reform law took a major step in terms of increasing funding in giving the Secretary a broader authority in doing, testing new ideas for Medicare. And we think that is a significant step in the right direction.

In order to meet the challenges that Medicare faces, of slowing the rate of increasing costs while preserving or even increasing the quality of care, we are going to need to change how Medicare pays for services. And the problem that we have had historically is that that process for testing new ideas is painfully slow. From conception to completion, we are often talking 7, 8, 9, 10 years.

At that rate, we will never get the job done.

The steps taken in the affordable care act we think have the potential to accelerate that process somewhat. We think that is very important.

I would add, however, one of my biggest concerns is that let's assume, as I think we all hope, that we can run some successful demonstrations and develop new ideas that work, those ideas need to then be operationalized by CMS. And I worry that even though we have given more funding, more funding for the research and demonstration, we are still chronically underfunding CMS operations.

And if we continue in that pattern—we can have all the great ideas in the world—they won't get implemented, or it will get implemented poorly, and we won't be any better off than we are today.

Mr. GREEN. That brings up the next question. You also mentioned that newly created Center for Medicare Innovation, which was authorized under the health care—health reform law. Mr. Whitfield and I have been working on a demonstration project we think that meets the criteria for a CMI demo, and the health reform law provides CMI with $10 billion in funding to carry out these new demonstration projects, which, in my opinion, is a sizeable amount of money. It may not be enough, because hopefully we will see lots of ideas that can deliver a more effective and even a more reasonable cost delivery of medicine. Yet your testimony indicates that there may not be enough funding four CMS to carry out all the demo projects, even though none have been taken up yet because, frankly, it has only been the law for a very short time.

And what are the issues that may cause CMS—even though none of it has been taken up, this may cause issues within CMS with the fee-for-service models. Can you discuss your statements on the Center for Medicare Innovation and the CMI?

Mr. HACKBARTH. I would agree, Mr. Green. The $10 billion funding is substantial, a huge increase compared to what CMS has had historically for this activity. So I don't mean to be critical of that at all. I think it is a big step forward.

I do think it is important for Congress to be sensitive to the complex task that CMS now faces. There are a lot of potential candidates for new projects, and these new projects are still going to take time to set up, operationalize, get running. And then it is going to take time to get results. So even with $10 billion, this isn't going to happen with the snap of a finger.

And then there is, as I said a minute ago, still the issue of about let us assume the best case, that we have successful demos; we still need resources in CMS to operationalize. It is a good step, but we need to be realistic. We have got problems still to solve.

Mr. GREEN. Mr. Chairman, I have other questions. I know I have run out of time, even without giving an opening statement. So if we could submit questions later and get responses back.

My next question. In your report, you state about half of the imaging studies were performed the same day in the office visit. You state that this is a reason to reevaluate the in-office ancillary exemption, and I assume because you feel that is a low number. However, this number of 50 percent seems to be quite—that quite a few evaluations of patients' conditions were helped by being able to quickly diagnose an issue by performing an imaging study in the office.

And I would imagine that clinically valid reasons when a physician may not want a patient to—may want a patient to rest and

then revisit if the condition doesn't improve would lead to an imaging study done on a different day. If half are performed on the same day, it would appear that we are meeting a test for the need for the self-referral exemption of timeliness, convenience and coordinated care that same-day diagnosis allows for. Do you feel that this is a low number, the 50 percent? Or is it unrealistic to expect that this would be considerably higher?

Mr. HACKBARTH. What we were trying to do is provide some data on what was one of the original reasons for having an in-office ancillary exception to the self-referral, and that was to allow same-day treatment in imaging. So what we did was look, in fact, at whether that is the case, and what we found was that for some services covered under the exception, therapy services, it was rarely the case that they were provided the same day. For advanced imaging, MRIs, CT and the like, it was provided same day less frequently than in half the visits. And then for the standard imaging, standard X-ray and the like, that was about half the time. And so there is variability depending on the particular service.

But I would emphasize that this is an area where we need to tread carefully. There are some legitimate rationales for allowing physicians to do these services, including potentially accelerating diagnosis and treatment, making sure that the patients get the needed tests and the like. In other contexts we sing the praises of integrated practice. So it is not so much the integration that is a bad thing. It is not so much the physician ownership that is a bad thing. It is the combination of physician ownership with fee for service and often mispriced services. It is that combination that can be toxic and lead to overutilization of services. So we are trying to figure out ways to solve the problem without throwing the baby out with the bathwater.

Mr. GREEN. Because I understand you have an endocrinologist, its ability to give a bone density test literally in the office there, it saves the time for another office visit for them to go get a test somewhere else.

Mr. Chairman, I know I have run out of time, and I would like to submit the remaining questions. Thank you.

Mr. PALLONE. And I will mention that any Member can submit questions in writing, and we will ask that you get back to us as soon as you can.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Thank you, Mr. Hackbarth, for being here.

You spent a chapter of the report discussing shared decisionmaking and its implications in Medicare. And I found it interesting that there was no explicit discussion of shared decisionmaking around care provided at the end of life. And especially given my sense that there is a fairly profound amount of end-of-life care that is provided that is not necessarily aligned with a patient's wishes or values, I wonder if this omission is because you see these issues as being distinct. Or, in fact, could you share—could you share with us your thoughts on shared decisionmaking between physician and patients to improve care at the end of life?

Mr. HACKBARTH. What we did in the chapter is our staff went out and looked at some of the existing programs for shared deci-

sionmaking. It wasn't the whole universe of programs where a representative sample—we went to a number of them. And the programs that we looked at, they did not tend to be focused on end-of-life issues; they tended to be more focused on treatment for breast cancer or prostate cancer or some of those examples.

The potentially rich opportunity for shared decisionmaking is in what some people call preference-sensitive care, where the right care is not something the physician can decide, it depends on how the patient assesses various risks, benefits, different potential outcomes. So shared decisionmaking is a way of helping the patient express their preferences. Given that as the underlying logic, it would seem that it could be applied to end-of-life issues. But as we looked at the programs that we describe in the report, that was not their principal focus.

Ms. BALDWIN. In the report I commend you for spending as much time and energy as you did looking at models to serve dual-eligible beneficiaries. These are folks who suffer not only from debilitating health conditions, but also from a system that leaves them with often poorly coordinated care.

In your report you mention special needs plans, and specifically you profile a successful program that we have in my home State of Wisconsin. Yet there is also notation that these programs vary significantly across the country. So I am wondering if it is your expectation that the new requirements that special needs plans establish State contracts will improve the quality and consistent—I have a follow-up question about the National Committee For Quality Assurance and their role in this.

Mr. HACKBARTH. Yes. A couple of years ago—I am not going to be able to remember the exact date—we did a chapter focused on SNPs, on this special needs plans, and made a series of recommendations there. And one was that—for the plans focused on the dual eligibles, that it was very important for there to be a contract with the State that specifies a lot of important operational details. And so we think that the requirement in the Affordable Care Act that there be contracts is a step in the right direction.

Not just any old contract will do. It is important that the content be right, to be sufficiently detailed and the like. But we do think that is a step in the proper direction.

Ms. BALDWIN. Then you focus again in this chapter on the importance of measuring outcomes, yet I think we lack information both on the best quality measures and the actual outcome data from the plans. So I understand that the National Committee For Quality Assurance is developing some additional reporting, but whose responsibility should it be to collect and analyze this data? Does there need to be congressional action to require this, or is it already within the powers of the agency and part of their obligation under the law?

Mr. HACKBARTH. Let me just begin first with full disclosure. Until very recently, a month or 6 weeks ago, I was a Board member at NCQA. So I just wanted to put that in the record.

Ms. BALDWIN. Thank you.

Mr. HACKBARTH. In terms of who does the actual development of the standards and measuring of performance, typically in an NCQA accreditation program, they are specifying the data required and

evaluating the performance against that data. And then CMS basically piggybacks on that. So I would think that is the way the process is working.

Am I misunderstanding your question?

Ms. BALDWIN. I am just wondering whether there needs to be additional congressional authority at this point in time. Is it already within the powers of the agency and part of their obligation under law to do this analysis?

Mr. HACKBARTH. Well, rather than risk an erroneous answer, can I respond to that request in writing?

Ms. BALDWIN. Absolutely. And since I have already expired my available time, that would probably be preferred by all. So thank you.

Mr. HACKBARTH. Thanks.

Mr. PALLONE. Thank you.

The gentleman from New York, Mr. Weiner.

Mr. WEINER. Dr. Hackbarth, thank you for being here.

I think that there is broad agreement that we need some kind of a model to go take a hard look at Medicare, try to figure out ways to save money. But when there was a proposal to expand MedPAC, a lot of us during the deliberation on the health care reform were very much against it because there is a general sense that there is a bias against big cities, there is a bias against graduate medical education. And unfortunately, the report—the most recent report kind of reenforces a certain tone deafness on some of this stuff.

And I think that the report does some remarkable things, but when it talks about a 3½ billion cut to IME funding in the exact same document where it points out that many teaching hospitals have negative margins presently, and further ignores the idea that we are in this movement, as you have testified to, of trying to move away from more and more people going into emergency rooms and more and more people seeing primary care physicians, it just seems to me that it is wildly counterintuitive. And it is not a question, but I would be glad to hear your response.

Mr. HACKBARTH. First of all, I just want to be clear that we are not recommending a $3½ billion cut. What we are recommending is that at a point in the future, at least 3 years in the future, that teaching institutions be held accountable for their performance, and that money, that 3½ billion, be contingent on performance. The 3-year period would be used to engage both the teaching hospitals, people in academic medicine, patient representatives, purchasers, health care delivery organizations in the development of those standards.

Our fondest hope is that every cent of the $3½ billion would be paid out, because that would mean that good standards have been developed, and the programs are performing well against those standards.

Mr. WEINER. So on page 102, recommendation 4–1 does not suggest the cost savings.

Mr. HACKBARTH. Our goal—as I said, our hope would be there would be no reduction in Medicare expenditures. That would signify that the programs are achieving the job, they are being accountable for——

Mr. WEINER. Right. Let me spend a moment on self-reform. You identified—I mean, there are various numbers in the report, but it is something like 104 percent overpayments, we think, for self-referral, and there was some consideration and the consideration of the health care reform bill again to basically ban wide swaths of the self-referral, include them under the START.

You have shown in your report that an overwhelming number—the costs go up overwhelmingly for second- and third-day referrals. Can you tell us, is there any reason we should still permit physicians who clearly are conflicted from doing radiology, from doing MRI, from doing these various things? I mean, the evidence seems—it seems so clear that it is not that doctors are being venal, but they have got this giant machine sitting in their office, they have got to make payments on it, it just seems like too great a temptation. Isn't there a much more bright-line recommendation we can make here to simply say just don't permit those self-referrals anymore? I mean, this is no longer the type of thing where maybe you say only if it has to be in an emergency, where someone walks in with a sprained ankle where you want to do an X-ray—which, by the way, as you know, is the reason any exemption exists in the first place. I think—I mean, it just seems to me that we are past points of dancing around this, and I think that that type of prohibition is in order.

Mr. HACKBARTH. As I was saying earlier, before I took this job, I was the CEO of a very large physician practice in Boston, 500 physicians, all sorts of——

Mr. WEINER. Your career is not taking the best projectile so far.

Mr. HACKBARTH. We all make choices.

We, my group, brought high-end imaging MRIs, CT, in house. We thought it improved our ability to effectively manage the care, coordinate the care, assure the quality of the imaging and the like.

A lot of notions of where the health care system needs to go in the future is towards more integration; not having all these separate, independent providers, but more organized systems. If we want to move in that direction, we don't want to discourage ownership.

The problem isn't the ownership per se; It is the combination of ownership with fee-for-service payment and mispricing of services. So there is easy profit opportunities. That is the toxic combination. It is not one; It is the three of them together. So what we are trying to do is identify options that allow us to preserve the good part of integration while doing away with the bad part.

Mr. WEINER. I have to say in my remaining—actually my time has expired. Let me just say that if we are going to get—if we are going to get your organization to a place that we really see it as a tool to start to do more of these savings and reenforce some of the good work you are doing in the report, you do have this institutional sense—and Mr. Pallone talked about it during the debate on health care—this institutional sense that you don't get it when it comes to teaching hospitals, but more than a few Members have mentioned that.

But I yield back the balance of my time.

Mr. PALLONE. Thank you, Mr. Weiner.

The gentleman from Ohio, Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

And thank you for your testimony today.

I come from a very rural area of Ohio. It is a large district in southeastern Ohio, exclusively rural. The largest town we have is about 27,000 people. And we have historically suffered from an inadequacy of physician workforce, and I think that is something that is probably true for most rural areas around the country, especially those that are relatively indigent or poor.

Can you talk about why this deficit is problematic in the context of its impact on creating a rural workforce?

Mr. HACKBARTH. Mr. Space, which deficit are you referring to?

Mr. SPACE. The deficit pertaining to access—not just family physicians, but physicians generally. And we have a difficult time recruiting subspecialists. We have a very difficult time recruiting primary care physicians. And I am curious as to your thoughts as to how that impacts creating the rule on workforce.

Mr. HACKBARTH. Clearly recruiting physicians is essential to provide quality care, and there certainly are documented problems in recruiting physicians in particular to rural areas, but also some inner city areas as well.

In our report, in the chapter on graduate medical education, we note that there are a number of programs authorized through this committee in the Public Health Service that are focused in particular on recruiting people into medicine that come from rural areas or inner cities or are drawn for certain minorities or ethnic groups. Although the research literature on the effect of those programs is not as robust as we would like to see it, that makes a lot of sense to us, because there is pretty good research that a physician who comes from a rural area is more likely to go back there.

Mr. SPACE. I think you could probably add to that—and maybe you have research that would corroborate this—but a physician who trains in a rural area is more likely to stay there. In fact, I read that in your report.

While we are on this subject, on page 117, figure 4–1 of the report, there is a graph that kind of outlines, I guess, third-year internal medical residents becoming subspecialists, or hospitalists. And it is actually quite remarkable. From 1998, we saw a predominance of general internal medicine somewhere in the neighborhood of 54 percent. That has shrunk to a 2007 level, it looks like around 25 percent, while subspecialties and hospitalists have experienced a marked increase. I have kind of a subquestion about that phenomenon. And I think your report quite correctly points out that we need to do something about that.

Mr. HACKBARTH. We do.

Mr. SPACE. It seems to me that in the end it is about money. It is about compensation or the lack thereof that drives folks into those fields. I think the same thing would apply to family medicine, family physicians, primary care. Short of increasing the compensation for, in this case, general internal medicine practitioners or decreasing the compensation paid subspecialists or hospitalists, what avenues are available for Congress to rectify what is a growing and increasingly large discrepancy for those who are training to become physicians?

Mr. HACKBARTH. Actually one of our Commissioners, Dr. Karen Borman, has published on this topic of why physicians choose various specialties. She is a program director in general surgery. And money is certainly one of the factors. But it isn't the only factor. Another important factor, in some cases even more important than money, is lifestyle, and do they envision living this job, and often that is a drawback about primary care. Physicians in training, they experience primary care while in training in an ambulatory clinic as way too many patients, way too few resources, and they say, this lifestyle is just not for me, this job is not doable.

So we do think that increasing payments for primary care relative to subspecialty care is a step in the right direction, but it may also be necessary to change how we pay for primary care. And as you know, that is part of the idea behind the medical home. Let us in addition to paying fee for service, pay per patient amounts that allow a primary care physician to build some infrastructure, hire some staff, to make the job more doable. So even if that money is not take-home pay, if it allows them to have a more robust practice, it can make primary care a lot more appealing.

And then there is the recruitment issues. Again, if you recruit people from rural areas into medical school and train them in rural areas, they are much more likely to do family practice in your part of Ohio than somebody who is trained in New York City.

Mr. SPACE. Are there tools available for the medical schools or even at the college level where I assume some of this recruitment is happening that would channel people early to take an interest in and begin pursuing a career in primary care rather than waiting until they are out of medical school and then throwing them into the GME program where they might be more inclined to focus on financial issues?

Mr. HACKBARTH. There are a number of programs in the Public Health Service that are designed to intervene earlier in the decisionmaking process and recruit people into medicine from diverse populations, and then encourage careers in primary care, because they are outside of Medicare. Frankly I don't consider myself real expert in all of the details, but generally speaking, we think that sort of earlier intervention effort holds a lot of promise and would urge a careful evaluation of those programs, the PHS, to see how we can build on them and make them as effective as possible.

Mr. SPACE. Thank you very much.

I yield back the balance of my time.

Mr. PALLONE. Thank you.

We have about—I don't know—7 or 8 minutes left. So we are going to conclude with Mr. Engel. When I say that, I mean, there are votes. I don't know if the Members realize we have 3 minutes.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman. I won't take the 7 or 8 minutes.

I just want to pile on Mr. Hackbarth because—about the IME, the indirect medical education. It is a major concern to my area, New York, New York City. And I echo everything that Mr. Weiner said. We are very, very concerned. There are many, many teaching hospitals in New York City. They have been devastated by cuts on the Federal and State level, whether it is DSH payments or in the health care bill that we passed. We had a whole fight over do-good-

er State provisions and things like that, And they have just been decimated back and forth.

And New York has 15 percent of the teaching hospitals. We train 15 percent of the doctors across the country. This is a really big thing for us. And I know you said that it wasn't a $3.5 billion cut per se, and that cut supposedly would fund a new incentive grant program under which these teaching hospitals would still see funding if they show they are furthering goals. But there are yet to be established goals by the Secretary of HHS, and the New York City teaching hospitals are very worried that they would lose up to $450 million annually. And that is just really untenable.

So I really—I understand that, but—what you just said before about you want to make sure there is quality. Of course you want to make sure there is quality, but at some point you can't get blood from a stone. And I think that these hospitals are just about at that point, and they are some of the best hospitals in the country, and every time we look for money or every time we look to so-called reform something, we hit them again and again and again. And at some point it obviously is going to affect the quality of care, or what they can provide, or how many nurses they can hire or things like that.

So I just want to echo what so many of my colleagues have said, and I really wish you would look again at that point, because our teaching hospitals just cannot afford even the whisper of cuts. It can have a very negative and debilitating thing that could happen to them.

Mr. HACKBARTH. Well, I certainly understand the anxiety about it, Mr. Engel, but, you know, that uncertainty often accompanies needed change. I don't think that in any sense whatsoever we are anti-teaching hospital, as Mr. Weiner suggested. The vote on this recommendation was unanimous. Two of the members of the Commission are deeply involved in medical education and graduate medical education training.

I have referred a couple of times now to my group in Boston. It was Harvard Vanguard Medical Associates. Our principal hospitals were the Brigham Women's Hospital and Children's Hospital.

I have no antipathy whatsoever towards teaching institutions, but we do think that the taxpayer, the health care system, the Medicare beneficiaries deserve some accountability in the use of the resources put into GME.

Mr. ENGEL. But you see, I am not going to argue with that statement, but I question whether the way you propose to go about it is the best way in going about it. Obviously we need to train tomorrow's doctors to have the appropriate skills to provide care in a modern health care system, but I just think slashing funds to teaching hospitals with no guarantee that they will be recouped, I don't think that is the best way to prepare future physicians. I think it causes a lot of angst, and I think it is negative.

And the reports that we have, I think that MedPAC reports that teaching hospitals now have negative Medicare margins, which obviously means Medicare is not covering the cost of caring for Medicare patients. You know, what could be the justification of everyone a whiff of cutting funding to teaching hospitals so that Medicare pays even less? It makes no sense to me.

Mr. HACKBARTH. I certainly do understand your perspective on it and take it really seriously. I do. At the same time, I hear from a lot of colleagues involved in academic medicine who believe the system needs to be reformed, believe that the teaching hospitals can do a better job of training physicians for the future, that Medicare is their last hope.

There is too much inertia in the system. Too many people do real well with the status quo. They need a catalyst for change. They need somebody to boost the prospects for reform in medical education. And these are people engaged in the system and say we need Medicare to be the lever that moves the system off the dot.

Mr. PALLONE. We are out of time. We have votes. I apologize, but I think we only have a minute and a half before we finish votes on the floor. So let me thank Mr. Engel and thank you also.

As you have heard, many Members want to submit written questions. We ask them to submit them within 10 days and then have you respond to them as quickly as you can.

But thank you so much for all that you are doing.

Without objection, the meeting of the subcommittee is adjourned.

[Whereupon, at 4:31 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert A. Berenson, M.D. F.A.C.P., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

The Honorable Henry A. Waxman

MedPAC has recommended increasing accountability for Medicare's GME payments by allocating a portion of total payments on the basis of performance in meeting newly established standards. As you testified, these standards would be developed by the Secretary of Health and Human Services in consultation with representatives of academic medicine and other stakeholders.

Several Members of the Subcommittee expressed concern about the sweeping effect this recommendation could have on teaching hospitals.

On the one hand, we must ensure the integrity of our safety net hospitals in times of financial distress, and Medicare's GME funds are an important form of support for critical safety net hospitals. On the other hand, there seems to be little doubt that our current GME system must modernize to train the workforce necessary for our health care system's needs.

1. **Why does MedPAC believe this is the right step at this time?**

Fundamental changes in our health care delivery system are essential to improve quality, better coordinate care, and reduce cost growth. To accomplish such delivery system reforms, we need to ensure that our medical education system produces physicians and other health professionals who can become leaders in reforming our delivery system to improve both its quality and value. The time is right to inject more accountability for meeting educational goals into Medicare's GME payment system, particularly considering its sizable investment ($9.5 billion in 2009).

In order to allow adequate time for the development of educational standards and criteria for the performance-based incentives, the Commission recommends that full implementation of performance-based GME incentives begin in three years (October 2013). This implementation date would also give hospitals and other qualified institutions time to consider ways they may need to change and improve their medical education programs and alter their operations to meet the educational objectives outlined in the standards. [All of this information and these recommendations are included in Chapter 4 of our June 2010 Report to Congress.]

2. **Is it possible to continue to ensure the fiscal stability of safety net institutions while simultaneously improving our GME system to ensure we are meeting our nation's workforce needs?**

Payment incentives in the graduate medical education system can be improved without jeopardizing the fiscal stability of safety net teaching institutions. Under this recommendation, all institutions are eligible for retaining their previous level of funding if they meet the established educational performance standards. Only institutions that do not respond to these incentives and do not meet the established standards would receive reduced GME payments. It is not the intent of our recommendation to take money away from safety net providers or the graduate medical education system.

Safety net institutions are a very important part of our health care system, and we understand your concern about ensuring their fiscal stability. Performance-based GME payments will help to improve both resident education and care delivery at teaching institutions – ultimately benefiting the residents, the patients, and the institutions. Additionally, in Chapter 3 of our June Report we discuss our exploration of better targeting Medicare's quality improvement resources to support safety net hospitals.

3. These recommendations have raised concerns by many. Can you tell us about the MedPAC Commission's vote on these recommendations?

The Commission vote on this recommendation was unanimous. Prior to the vote, the Commissioners met and publicly discussed the topic of improving graduate medical education over a two-year period. The Commissioners raised many options during these meetings, but ultimately this recommendation reflects a unanimous consensus among the Commissioners on the importance of (1) better education and training of our physicians and other health professionals in skills necessary to improve our health care delivery system; and (2) increased accountability of Medicare's dollars spent on graduate medical education.

The Honorable Anthony D. Weiner

1. **Given that anatomic pathology services cannot be performed during the patient's office visit and the vast majority of outpatient advanced imaging services and outpatient physical therapy services are not performed on the day they are ordered, do you believe these services should be categorized as ancillary and therefore exempted from the Stark self-referral laws?**

In Chapter 8 of our June 2010 Report to the Congress, we described several options to address concerns raised by the growth of ancillary services in physicians' offices. Proponents argue that physicians who provide in-office ancillary services (IOAS) are able to improve care coordination, better supervise the quality of diagnostic tests, and receive test results faster. The Commission is concerned that the in-office ancillary services exception leads to higher utilization. The Commission has also raised concerns about the availability of quality in the office setting. In future work, we intend to further explore these options with the goal of crafting policy recommendations. One policy option we describe would exclude diagnostic tests that are not usually provided during an office visit from the in-office ancillary services exception. Another option would exclude outpatient physical therapy and radiation therapy from the exception. Both options have pros and cons, that we intend to explore in future work.

2. **I understand that some private health plans are not reimbursing for tests performed in-office unless the tests can be performed during a patient's office visit. Does CMS have any plans to follow this approach, which is meant to stem overutilization of in-office testing?**

The Commission is not aware of any plans by CMS to not reimburse providers for tests performed in a physician's office unless the tests can be performed during an office visit. However, we will monitor any policy changes proposed by CMS in this area.

3. **As you mentioned at the hearing, utilization of anatomic pathology services, high end imaging, and physical therapy services is increasing due to allowing physicians to bill for these services under an exception to the self-referral prohibition laws for in-office ancillary services. Such high utilization is costing Medicare money. Is CMS aware of this and what is it doing to fix the problem? What are the regulatory options for fixing the problem?**

In the proposed rule for the 2008 physician fee schedule, CMS noted the migration of expensive imaging equipment, pathology services, and physical therapy to physicians' offices and asked for comment on whether the in-office ancillary services exception should be changed. For example, CMS asked whether services that are not needed at the time of the office visit to help the physician diagnose or treat the patient should continue to qualify for the exception. To date, CMS has not proposed a specific policy change. In our June 2010 Report to the Congress, we described several options to address concerns raised by the growth of ancillary services in physicians' offices. In future work, we intend to further explore these options with the goal of crafting policy recommendations.

The Honorable Mike Rogers

1. **MedPAC is aware that many clinically integrated cancer practices and organizations exist today. In fact, it is my understanding that over 80% of cancer patients are treated in community-based private oncology practices and many of these oncology practices have incorporated radiation therapy services to provide comprehensive, coordinated care in a clinically integrated fashion.**

a. **Has MedPAC undertaken an assessment of the potential effects of excluding radiation therapy from the IOAS exception in terms of these clinically integrated practices and the resulting disruption and reduction in patient access to care?**

In our June 2010 Report to the Congress, we described several options to address concerns raised by the growth of ancillary services in physicians' offices. In one of these approaches, outpatient therapy and radiation therapy would be excluded from the in-office ancillary services (IOAS) exception based on the rationale that physician investment in therapeutic services may skew clinical decisions about the treatment of patients. We have met with integrated cancer practices to understand the implications. We understand that this change would affect clinically integrated groups that include both medical and radiation oncologists, which lead us to another possible approach. In this approach, the IOAS exception could be limited to physician groups that can demonstrate clinical integration. The goal of this option is to balance the risks of higher volume associated with self-referral with the potential benefits of clinically-integrated practices. A key issue under this approach would be how to define clinical integration. In future work, we intend to further explore the pros and cons of these and other policy options.

2. **It is my understanding that clinically integrated cancer care is essential for patient access to the radiation therapy clinical trials that often represent the best hope for progress in identifying future effective treatments for cancer. Many hospitals and stand-alone radiation oncologists are not able to participate in radiation therapy clinical trials because they often lack the dedicated infrastructure found in clinically integrated cancer care practices, which includes: research trained personnel; standard operating procedures and extensive data management systems. Further, many of the latest trials pursued by the Radiation Therapy Oncology Group (RTOG), an NCI cooperative group, actually require the concomitant delivery of radiation therapy and chemotherapy in the trials, something not possible outside of integrated practices and academic medical centers.**

a. **Has MedPAC considered the impact of excluding radiation therapy from the IOAS exception on our nation's ability to conduct these essential cancer care clinical trials?**

We appreciate your raising this issue. While this issue has been raised in our meetings with oncology practices, we have not yet considered the potential impact of excluding radiation therapy from the IOAS exception on clinical trials for cancer treatment. MedPAC often raises

possible approaches to changes in policy well in advance of voting on recommendations precisely for this reason -- so that issues like this come to our attention.

3. In providing the option to remove radiation therapy from the IOAS exception, MedPAC has raised questions about arrangements in which a physician group employs a radiation oncologist who may bill Medicare directly and reassign payments to the physician group.

a. Could you please provide an example of such a typical arrangement and, in particular, the kind of specialty group that might employ the radiation oncologist?

According to an article in *The New York Times*, some urologists have been working with private companies to set up radiation therapy centers for their prostate cancer patients.[a] In these arrangements, the urology group hires or partners with a radiation oncologist. In our June 2010 Report to the Congress, we also noted the existence of groups that include both medical and radiation oncologists that treat a wide variety of cancers. We do not have information about whether the radiation oncologists in these groups are owners, employees, or independent contractors of the group.

b. Also, would you please distinguish how such an arrangement might differ from a truly clinically integrated cancer practice?

It is unclear how to define a truly clinically integrated cancer practice. In our June 2010 Report to the Congress, we describe a possible approach for determining whether a physician group is clinically integrated for the purposes of the in-office ancillary services exception. Under our proposed definition, a clinically-integrated group is one in which each physician in the group provides a substantial share of his or her services —such as 90 percent—through the group. This rule would apply to owners, employees, and independent contractors of the group.

4. MedPAC has explicitly acknowledged the value of the care provided by clinically integrated cancer care practices to Medicare beneficiaries.

a. Can MedPAC assure this committee that the hundreds of thousands of Medicare beneficiaries fighting cancer that are currently benefiting from truly clinically integrated cancer care would continue to receive such high quality care under a policy removing radiation therapy from the IOAS exception?

In our June 2010 Report to the Congress, we described several options to address concerns raised by the growth of ancillary services in physicians' offices, including a strategy of excluding outpatient therapy and radiation therapy from the in-office ancillary services (IOAS) exception. In evaluating the strengths and weaknesses of this option, a key issue is whether it would have an impact on beneficiaries' access to quality care. Medicare should seek to maintain beneficiaries'

---

[a] Saul, S. 2006. Profit and questions on prostate cancer therapy. *The New York Times*, December 1.

access to high-quality care while encouraging efficient use of resources. MedPAC would keep beneficiary access as a key focus as it considers recommendations.

5. **The health reform bill contemplates several delivery system reform policies, such as accountable care organizations, aimed at integrating our fragmented healthcare system. Such strategies should be careful to not limit the development of accountable care organizations that MedPAC states in this report could generate significant savings for Medicare.**

a. **Does MedPAC believe that the potential effects of removing radiation therapy from the IOAS exception are consistent with the delivery system reform policies in the health reform bill?**

The Commission has noted that physician self-referral of radiation therapy and other services covered by the in-office ancillary services exception creates incentives to increase volume under Medicare's fee-for-service payment systems, which reward higher volume. Therefore, the Commission's preferred approach to address self-referral is to develop new payment and delivery systems that reward providers for constraining volume growth while improving quality of care. For instance, if there were a truly functioning ACO that is held accountable for utilization and quality, we would not have concerns about self-referral. Because it will take several years to develop new payment models and delivery systems, policymakers may wish to consider interim approaches to address concerns raised by self-referral. Such strategies should be careful to not limit the growth of accountable care organizations that could save money for Medicare and beneficiaries while improving quality.

b. **Relative to such a policy, does MedPAC believe that allowing truly clinically integrated cancer practices would be more consistent with the health reform bill's delivery system reform policies?**

The Commission believes that today's health care delivery system is not a true system: Care coordination is rare, specialist care is often favored over primary care, and quality of care is often poor. A reformed delivery system would pay for care that spans across provider types and encounters and would hold providers accountable for the quality of care and the resources they use to provide it. There is the potential that an integrated cancer practice could meet the goals of a coordinated delivery system.

6. **Crafting a workable definition of "clinically integrated" physician practices is critical when it comes to cancer care.**

a. **What kinds of criteria is MedPAC considering for this definition?**

In our June 2010 Report to the Congress, we describe a possible approach for determining whether a physician group is clinically integrated for the purposes of the in-office ancillary services exception. Under one possible definition, a clinically-integrated group is one in which

each physician in the group provides a substantial share of his or her services —such as 90 percent—through the group. This rule would apply to owners, employees, and independent contractors of the group. However, there may be additional definitions for clinical integration. For example, additional criteria could include agreed upon clinical pathways and EHRs to better track patients and coordinate outcomes. We are meeting with cancer practices to better understand possible definitions and criteria. We will discuss this approach and others again when we convene the Commission in the fall.

b. **Is MedPAC working with affected stakeholders to ensure these policy criteria would continue to allow for truly integrated physician practices?**

As a matter of course, MedPAC gathers input on our policy deliberations through meetings with key stakeholders – both associations and individual health care providers and beneficiaries – as well as experts in health care policy and medicine. In 2009, MedPAC held more than 200 such meetings. MedPAC also solicits information from experts and stakeholders through the public comment sessions during our public meetings and through written comments on MedPAC's website.

○