A PERMANENT SOLUTION TO THE SGR: THE TIME IS NOW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JANUARY 21 & 22, 2015

Serial No. 114–2

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

U.S. GOVERNMENT PUBLISHING OFFICE

20–310 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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[1] The attachment to Mr. Umbdenstock's statement can be found at: *http://docs.house.gov/meetings/if/if14/20150122/102827/hhrg-114-if14-wstate-umbdenstockr-20150122.pdf*.

A PERMANENT SOLUTION TO THE SGR: THE TIME IS NOW, DAY 1

WEDNESDAY, JANUARY 21, 2015

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

The subcommittee met, pursuant to call, at 10:17 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton, Green, Engel, Capps, Schakowsky, Castor, Matsui, Lujan, Schrader, Kennedy, Cardenas, and Pallone.

Staff Present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, O&I; Robert Horne, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Macey Sevcik, Press Assistant; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Minority Policy Analyst; Jeff Carroll, Minority Staff Director; Eric Flamm, Minority FDA Detailee; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; and Arielle Woronoff, Minority Health Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Good morning, ladies and gentlemen.

The subcommittee will come to order.

The chair will recognize himself for an opening statement.

I would like to welcome everyone to the first Health Subcommittee hearing of the 114th Congress and officially welcome our new members on both sides. On our side, we have Larry Bucshon, Susan Brooks, Chris Collins, and Billy Long, who is on the committee, is now on the subcommittee, Health Subcommittee. So they will be a great addition.

This subcommittee has made permanent repeal of the flawed Medicare sustainable growth rate formula, or SGR, a top priority for the last 4 years. In 2014, we reached a bipartisan, bicameral agreement on a replacement policy that enjoys widespread support both in Congress and among the stakeholder community.

With the current doc fix expiring in less than 2 months, at the end of March, we are faced with the best opportunity in a decade to permanently dispose of the SGR. We are committed to rising to meet this challenge.

And now, with the policy agreed to, the question we face is how to responsibly pay for SGR reform in a manner that can pass both houses of Congress and be signed by the President. Coming up with approximately $140 billion in offsets will not be easy, but it is a task we must embrace.

Some argue that SGR reform does not need to be paid for. I respectfully disagree.

First, if Members are serious about seizing this historic moment to pass SGR reform, as a purely practical matter, for the bill to pass the House of Representatives and Senate it must include sensible offsets. For example, in recent years, the Senate already tried to pass a full repeal of the SGR under a Democratically controlled Senate. On October 21st, 2009, the Senate considered Senator Stabenow's bill, S. 1776, and that bill failed on a 47-to-53 vote even though there were 60 Democratic votes in the Senate.

Second, the American people expect Congress to live within our means. The American people expect Congress to reduce the debt and prioritize spending. It is our responsible to lead accordingly.

Third, not paying for SGR reform would ignore past precedent from Congress, whether it was controlled by Democrats or Republicans. As the Center for a Responsible Federal Budget has noted, "Lawmakers deficit-financed the first doc fix back in 2003 but since then have offset 120 out of the 123 months of doc fixes with equivalent savings. That is 98 percent."

So today we are here to take the next step in our process, discussing a range of commonsense Medicare policies which can improve, modernize, and strengthen Medicare. Most of the policies we will be discussing have been endorsed by Members of both political parties, included in the President's Fiscal Commission recommendations or included in one of the President's budgets submitted to Congress.

As we move forward to get SGR reform across the finish line, we look forward to be discussing these and other options with the minority and the Members in the Senate.

And we are very happy to have with us today some extremely well-respected thought leaders who have demonstrated they are serious about helping save and strengthen Medicare and doing so in a bipartisan manner.

So I welcome all of our witnesses. We look forward to hearing your testimony.

[The prepared statement of Mr. Pitts follows:]

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Mr. PITTS. And I yield the remainder of my time to our new vice chair, the gentleman from Kentucky, Mr. Guthrie.

Mr. GUTHRIE. Thank you, Mr. Chairman.

And I appreciate you holding this hearing and the opportunity to discuss the SGR, a critical issue for our Nation's seniors. And since coming to Congress, I have heard repeatedly from Kentuckians that solving the SGR permanently is essential for beneficiaries to have continued access to the care they rely on.

I am proud of the work this committee has done over the past few years to get to this point. We have a bipartisan, bicameral replacement proposal that will repeal the SGR and move forward with a new payment structure that focuses on quality and innovation.

Unfortunately, the issue of how we offset the $140-billion price tag for SGR is still unresolved. We must continue to focus on finding ways to pay for the SGR proposal, and I want to specifically thank our panelists today and tomorrow who have put forward thoughtful proposals.

I am hopeful this hearing will be the beginning of meaningful discussions and produce real bipartisan, commonsense solutions to the real SGR, reduce Medicare costs, and protect the beneficiaries.

And to echo what the chairman said, we have a very distinguished panel, very important thought leaders.

And it is very much appreciated that you guys are here today.

Thank you.

Mr. PITTS. The chair thanks the gentleman.

I am now very pleased to recognize our new ranking member, the gentleman from Texas, Mr. Green.

I look forward to a good session working together.

Five minutes.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

And like you, we have some new members of our subcommittee. Congressman Lujan has been on our committee, full committee, but he is new to our subcommittee. And also new members to the full committee is Congressman Kurt Schrader from Oregon, who is new to the Energy and Commerce Committee and obviously new to the Health Subcommittee, and also Congressman Joe Kennedy from Massachusetts.

Welcome, both of you, to the full committee and also to the Health Subcommittee.

And, Ben Ray, you have been around a while. I am glad you are on Health now. So, appreciate it.

Our other Members new to our Health Subcommittee and the committee: Tony Cardenas, who is not here right now but will be on the committee, and so will Doris Matsui and John Sarbanes, new members on the subcommittee.

Thank you, Mr. Chairman, and thank our witnesses for being here today.

Eliminating the sustainable growth rate, or the SGR, formula under Medicare will represent a major policy development. It is critically important that Congress institute a reasonable and responsible payment policy for physicians and reward value over volume.

The repeal-and-replace legislation negotiated last Congress made a historic agreement between the House and Senate committees of jurisdiction. Together, a bipartisan bill was introduced to permanently repeal the SGR and replace it with a value-based system that provides stability for physicians and maintains beneficiary access.

Since 2003, Congress has enacted 17 patches to delay cuts to Medicare physician payments derived from the flawed SGR formula. The total cost of these 17 patches has been $169.5 billion. This amount exceeds the current cost of the bipartisan repeal-and-replace legislation developed last Congress. The Congressional Budget Office projects an SGR fix will cost $144 billion over the next 10 years.

Insisting SGR reform to be fully offset is a tough issue and a policy my Republican colleagues frequently abandon when it is politically convenient. Last week, the House passed a bill changing the definition of a full-time employee from 30 hours a week to 40 hours. It added $53 billion to the Federal deficit over 10 years, but it was not paid for. And it passed the House.

Responsible Federal spending is important; however, offsetting the cost of the SGR on the backs of the beneficiaries is unacceptable. Seniors already pay their fair share of Medicare. Half of all beneficiaries live on less than $24,000 a year. On average, health

expenses account for 14 percent of Medicare-household budgets. That is nearly three times as much as non-Medicare households.

Most of the proposals for Medicare savings would increase what is already a substantial burden on beneficiaries and increasing out-of-pocket costs and limiting access to services.

It is important to note that the Medicare program is stronger than ever. The 2014 Medicare Trustees Report estimates that the Medicare Part A trust fund will now be solvent until 2030, 4 years longer than it was estimated in 2013. This is in part because of reforms in the Affordable Care Act.

Projected Federal spending for Medicare and Medicaid has fallen by almost $1 trillion since 2010. When compared to the Congressional Budget Office's August 2010 and August 2014 baselines, Medicare spending this year will be about $1,200 lower per person than expected in 2010.

Controlling costs alone without considering revenue is not a realistic approach to Medicare solvency and putting our Nation's seniors at risk. The flawed SGR formula has plagued our healthcare system for too long, but a fix in SGR that harms Medicare beneficiaries because of an insistence on offsets that reduce benefits and limit access is not an acceptable tradeoff. And I urge our colleagues to work together and enact a long-term, overdue SGR reform for our seniors.

And, with that, Mr. Chairman, I would like to ask unanimous consent to place into the record a letter signed by 17 national nonprofit agencies, a statement from Stand for Quality, and a letter from the American Federation of American Hospitals. I ask unanimous consent to have that placed into the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GREEN. And, with that, I will yield the remainder of my time to our colleague Congressman Kennedy.

Mr. KENNEDY. Thank you to the ranking member for yielding briefly.

Thank you to the chairman for calling the hearing, and thank you for letting me join you. It is an exciting day for me. So, glad to be here.

Like most of my colleagues, I was hopeful that last year's strong momentum to pass an SGR fix would result in bipartisan legislation that meets the needs of both beneficiaries and workers and providers as well. I am even more hopeful that we can reach an agreement that doesn't pass these costs to fix the system on to America's seniors.

Half of all the Medicare beneficiaries live on less than $23,500 a year, and health expenses accounted for more than 14 percent of Medicare-household budgets in 2012. These numbers tell a startling story about the economic reality most seniors face.

As we take up a renewed push to fix the SGR, let's keep seniors at the forefront of this debate. They have earned their benefits. Now let's make sure we can afford them.

I also want to thank the witnesses for being here today.

Senator, thank you for your service to your country.

Mr. PITTS. The gentleman yields back.

The chair recognizes the chairman of the full committee, the gentleman Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Pitts.

This week's hearing is indeed an important opportunity to discuss bipartisan reforms to strengthen and improve the Medicare program while helping achieve the savings needed to pay for a permanent solution to the flawed SGR.

Last Congress, this committee, along with our colleagues at Ways and Means and Senate Finance, came to an agreement on policy to finally remove the uncertainty that has plagued seniors and their doctors for way too long. Still to be resolved was a path to pay for this important policy change.

The experts here this week will help us explore some bipartisan proposals to both strengthen the Medicare program as a whole while also finally removing the threat of the SGR permanently.

This is an historic opportunity. Securing a permanent solution to the SGR is more than tinkering with how we pay doctors who treat Medicare patients. This can also be Medicare reform.

And while it is important to pay for the policy, I want to caution us about framing our discussions as one of merely budgets or beneficiaries. The truth is Medicare's budget is out of control and the program is on the fast track to insolvency. That threatens the long-term access to care for millions of deserving seniors who depend on the program. That is not right.

So the most pro-beneficiary reform that we can adopt this Congress are ones that will not only remove the threat of SGR but also shore up the Medicare program with sensible reforms that make the programs more sustainable for years, perhaps generations, to come.

Failure to pass a permanent SGR before March would not be due to a lack of policy options but a failure of Congress to work together on offsets with the same bipartisan spirit that we exhibited on the policy itself. This subcommittee has proven that it is indeed capable of working together, and I think that we are ready to do it again. I am absolutely committed to working with my colleagues on this committee and the House and the Senate to finally get it done.

There is a path forward. It involves targeted reforms, which save money without cutting care. It involves a balance of pay-fors, which are bipartisan policies. And it involves a spirit of cooperation with sustained commitment.

Seniors in my State and others and across the country deserve the peace of mind that their trusted doctor will be able to answer their calls for care.

[The prepared statement of Hon. Fred Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

This week's hearing is an important opportunity to discuss bipartisan reforms to strengthen and improve the Medicare program while helping achieve the savings needed to pay for a permanent solution to the flawed Sustainable Growth Rate. Last Congress this committee, along with our colleagues at the Ways and Means Com-

mittee and Senate Finance Committee, came to an agreement on policy to finally remove the uncertainty that has plagued seniors and their doctors for too long. Still to be resolved was a path to pay for this important policy.

The experts here this week will help us explore some bipartisan proposals to both strengthen the Medicare program as a whole while also finally removing the threat of the SGR permanently.

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And while it is important to pay for this policy, I want to caution us about framing our discussions as one of merely budgets or beneficiaries. The truth is, Medicare's budget is out of control and the program is on the fast track to insolvency. That threatens the long-term access to care for millions of seniors who depend on the program. So the most pro-beneficiary reforms we can adopt this Congress are ones that will not only remove the threat of the SGR, but also shore up the Medicare program with sensible reforms that make the program more sustainable for years to come.

Failure to pass a permanent SGR solution before March would not be due to a lack of policy options, but a failure of Congress to work together on offsets with the same bipartisan spirit we exhibited on the policy. This subcommittee has proven it is capable of working together, and I think we're ready to do it again.

I am committed to working with my colleagues on the committee, in the House and in the Senate finally get this done. There is a path forward, and it involves targeted reforms which save money without cutting care; it involves a balance of payfors which are bipartisan policies; and it involves a spirit of cooperation with sustained commitment. Seniors in Michigan and across the country deserve the peace of mind that their trusted doctor will be able to answer their calls for care.

The time is now. So let us begin.

Mr. UPTON. I yield the balance of my time to Dr. Burgess.

Mr. BURGESS. I thank the chairman for yielding.

I thank Chairman Pitts for calling the hearing.

Ranking Member Green, it is good to see you sitting at the top of the dais as well, sir.

It is important that this is the first hearing of this subcommittee in this term of Congress. This committee continues on a bipartisan basis to demonstrate previously unparalleled leadership in our efforts to repeal the sustainable growth rate formula. The countless hours of negotiations that Members and staff have devoted to this issue over the past 2 years have produced the only bipartisan, bicameral, tri-committee agreement, and that occurred on February 6th of last year.

This work——and I was proud to help the chairmen and the ranking members——was embraced by organized medicine, beneficiary groups, and payers, producing over 750 letters of support.

I want to thank the chairman for mentioning the votes that were taken in October and November of 2009. That was a particularly trying time for me. The Senate, of course, had the 60 votes, but they could not pass a repeal of the SGR. Then, in what really can only be marked as an episode of legislative futility, after it had failed in the Senate, Speaker Pelosi brought it up on the House side. Really solidifying my allegiance to the patron saints of lost causes, I was the only Republican vote for that bill that was brought forward in the House in November of 2009. But this is how strongly I feel about this issue.

If you go to a Web site called MedPage Today, the Number One clicked-on article last year was "Get Me Out of Here: Doctors Looking to Get Out of Medicine." And the SGR is the proximate cause for their dissatisfaction with the profession that they work so hard for and that they love so much.

So we have the bill, we have a draft, we are ready to go. All it takes is us agreeing to the offsets. It is hard work; I know it is difficult work. But I know this committee, this subcommittee is up to the task.

And I really would ask my colleagues on the other side of the dais, let's work together, let's get this done for the patients of America, for the seniors of America, and the physicians that take care of them.

And I yield back.

Mr. PITTS. The chair thanks the gentleman.

At this time is pleased to recognize the former ranking member of the Health Subcommittee, now the ranking member of the full committee, Mr. Pallone, for 5 minutes.

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

Mr. PALLONE. Thank you, Mr. Chairman.

And I want to thank you for ensuring that the issue of a permanent solution to the SGR is at the forefront of this Congress' agenda. In addition, holding a hearing early in the session allows our new Members an opportunity to review both the policy and congressional background on the SGR.

While I am very interested to hear from our two panels over the next 2 days, I strongly believe——and I hope the chairman does too——that after this hearing we should wait no longer to roll up our sleeves and get down to the work of ensuring the bipartisan, bicameral bill agreed to last year is enacted into law before the March 31st deadline.

We all agree on the policy. We all agree that bill, the previous bill, is a good compromise. It also, most notably, has the support of both provider and beneficiary groups.

The question that has plagued us, of course, is the offsets. And I believe that because the SGR is the result of a budget gimmick and we have already spent $169 billion paying to fix the problem, that offsets, especially those within our health programs, are not necessary. However, if we must include offsets, the war savings, which are known as the overseas contingency operations, or OCO, funds, could be used.

I know some on the other side of the aisle do not share my view. What I hope is that we can agree first that SGR shouldn't be paid for off the backs of beneficiaries. Beneficiaries will already pay for their share of the cost of SGR repeal through higher premiums, and half of all beneficiaries live on less than $23,500 per year.

And, second, this is not the time or the place to introduce controversial Medicare structural reforms or changes. These proposals, like raising the eligibility age or raising the deductible or additional means-testing, should not be considered in a vacuum and will become poison pills that will thwart the bipartisan progress that we have made on fixing the SGR problem.

And, finally, if there is consensus that offsets are required here, then revenue should be on the table. It is shortsighted and arbitrary to cut health programs simply because budget rules say so.

So I am hopeful that this is the year we can get the SGR done. If we do, it will be a bipartisan victory for Medicare, for physicians, and beneficiaries alike.

Mr. Chairman, with the time left, I would like to split it, a minute or so to Representative Matsui and then the rest to Representative Schakowsky, if I can.

Mr. PITTS. Without objection.

Ms. Matsui?

Ms. MATSUI. Thank you very much, Ranking Member Pallone, for yielding me time today.

We need to solve the SGR problem for our Medicare physicians and their patients, but we can't do it by causing new problems for Medicare beneficiaries. In fact, we should be providing more stability to seniors and people with disabilities by not subjecting the programs that they rely on to annual funding threats.

This committee worked very hard last year with our colleagues on Ways and Means and Senate Finance to come up with a bipartisan, bicameral policy solution to the flawed SGR methodology. Now is the time that we should be having serious discussions about how to move this forward. We should not kick the can down the road once again.

We need to move the system forward to reward value rather than volume, and we need to protect, strengthen, and expand Medicare and its programs. To do this, we need to make the so-called SGR extenders permanent.

The QI program provides premium assistance, and Aging/Disability Resource Centers provide no-wrong-door resources to the lowest-income beneficiaries. As a co-chair of the Seniors Task Force, I am acutely aware that more than half of Medicare beneficiaries live on incomes of $23,500 or less and cannot afford to pay more for their health care.

We owe it to our doctors and their patients to provide this much-needed stability in the Medicare program.

I yield back.

Mr. PALLONE. I yield to Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you.

I am also the co-chair of the Seniors Task Force of the Democratic Caucus, and I am concerned because Medicare beneficiaries currently find themselves in an all-too-familiar situation, worrying that they could lose their doctors if Congress doesn't reach an agreement on the doc fix.

And we do have an opportunity to end these worries forever. The Democrats, as Dr. Burgess, when we were in charge, pointed out, actually did that, a permanent repeal of the SGR. Passing the bipartisan, bicameral proposal would repeal the SGR formula and continue Medicare's transformation into a program that pays for quality, not volume.

In passing the legislation, though, we should follow the precedent set by Republicans, who consistently pass healthcare legislation without offsets. Just earlier this month, the Republicans passed a bill to redefine "full-time" under Obamacare that cost $53 billion without offsets.

If we must include offsets, then we must not cut benefits or ask beneficiaries to pay more. Let me just say that doing so would ex-

change beneficiaries' worries that their doctors will leave Medicare for worries that they can no longer afford to see their doctor under Medicare.

I yield back.

Mr. PITTS. The chair thanks the gentlelady.

That concludes the opening statements of the Members. As always, any written opening statements of Members will be made a part of the record.

Mr. PITTS. We have two panels——one today, one tomorrow——on this issue.

And before I introduce the panelists, I have a UC request to enter into the record comments of the American College of Clinical Pharmacy. Without objection, we will put that in the record.

So ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. On our panel today we have three witnesses: Joe Lieberman, highly respected former U.S. Senator——welcome, Joe——Dr. Alice Rivlin, Co-chair of the Delivery System Reform Initiative, Bipartisan Policy Center, and dDings Institution——I might add, former OMB Director under President Clinton and Vice Chair of the Federal Reserve——and, finally, Dr. Marilyn Moon, Institute Fellow at the American Institutes for Research.

Welcome. Thank you for coming. You will each be given 5 minutes to summarize your testimony. Your written testimony will be placed into the record.

Senator Lieberman, we will start with you. You are recognized for 5 minutes for your summary.

STATEMENTS OF JOSEPH I. LIEBERMAN, FORMER UNITED STATES SENATOR; ALICE RIVLIN, PH.D., CO-CHAIR, DELIVERY SYSTEM REFORM INITIATIVE, BIPARTISAN POLICY CENTER, AND DIRECTOR, ENGELBERG CENTER FOR HEALTH CARE REFORM, BROOKINGS INSTITUTION; AND MARILYN MOON, PH.D., INSTITUTE FELLOW, AMERICAN INSTITUTES FOR RESEARCH

STATEMENT OF JOSEPH I. LIEBERMAN

Mr. LIEBERMAN. Thanks, Chairman Pitts and Ranking Member Green, members of the committee. It is an honor to be asked to testify before you.

I must say that, a day ago, I got a call in my office from a reporter for a trade publication, and the essential question was, to my executive assistant, why is Senator Lieberman testifying about the SGR problem?

So the answer is that there is a staff member of the full committee, Josh Trent, who used to work for Senator Tom Coburn. And in 2011 Dr. Coburn and I spent a lot of time working together to try to come up with a bipartisan program to save Medicare and to reduce the national debt, and, after a lot of work, we did. And I hope that I can bring some of that experience to bear on what you are facing now.

Let me try to put it in this quick context of this morning's news. The President said last night in the State of the Union that the shadow of crisis has passed. And I would say, generally speaking,

insofar as the deep recession we were in, the economic crisis, the shadow has passed. But there are other very, very deep, dark shadows over our future that have not passed, one of which is, obviously, our continuing-to-grow national debt.

When Senator Coburn and I introduced our Medicare reform plan in 2011, the national debt was just at about a little over $14 trillion. It is 3 years later; we are now over $18 trillion. And this is really unsustainable. It is sustainable only at the risk of putting a terrible burden of taxation on our children and grandchildren or forcing really unacceptable cuts in spending in Federal programs.

The other crisis that has not passed relates to Medicare, which also is a big cause of the growing national debt. And the trustees of Medicare continue to say, just to make it as specific as I can, that Part A, the hospital insurance program, could be insolvent——which is to say, unable to pay the benefits due to seniors——as early as 2021 and maybe, under the best of circumstances, as late at 2030. So there is a real problem.

The second thing I want to say is thank you. I mean, beginning in this subcommittee, working with colleagues on other subcommittees in the House and Senate and both parties, you have done something that has been really generally unheralded in a time when Congress has been so gridlocked and unproductive: You have come up with not a fix, but a solution, a replacement, a reform of the sustainable growth rate formula for physician reimbursement, which hasn't worked. And now the question is, how do you pay for it?

Let me just say in passing, as others who have spoken have, as a Member of the Senate, certainly the public following this, certainly doctors, the SGR was a perpetual recurring crisis, a process crisis. People would use the need to fix it to attach all sorts of conditions to it and the rest.

But there are two positive notes out of that suffering that we all went through. One is, as you have said, that in almost all the cases, 98 percent, the cost of the fix was offset. The second, to me, encouraging reality was that, generally speaking——well, let me put it this way: that the most significant Medicare reforms that have passed in the last decade were passed to finance fixes for SGR.

So I would say first that I hope that you offset the cost of the solution, the repeal, the reform that you have come up with, because otherwise you are going to increase the national debt. That shadow is over our future.

The second thing is to say that I hope you build on this hidden story of offsetting your repeal and reform of SGR, replacing it, as predecessor Congresses have, by using it as an opportunity to reform some elements of Medicare.

And, obviously, I am happy to answer questions in the next section of the hearing, but I offer the work that Dr. Coburn and I did as an example. You don't fix the Medicare problem by making everybody happy, but the main thing you can do is to sustain this incredibly important, humane program for the long term.

Dr. Coburn and I negotiated back and forth, and we did some things that are not popular with everybody. We replaced Medicare's current complicated cost-sharing requirements with a unified an-

nual deductible of $550. But we also created an out-of-pocket maximum of $7,500 so every Medicare recipient would have a cap on annual medical costs to protect them from financial hardship or bankruptcy.

The Fiscal Commission, the President's commission, estimated that that kind of restructuring, along with the Medigap reform that we included, would save $130 billion over 10 years. The total savings estimated by the Centers for Medicare and Medicaid and the President's Fiscal Commission and CBO were somewhere in the $500 billion to $600 billion range over the next decade. And, startlingly, because this is big numbers, over the long term, our proposal would have reduced the unfunded liabilities of Medicare by $10 trillion because it just continues to grow.

We did reform Medigap to increase consumer utilization in a way that makes the system work better. We did recommend raising the eligibility age. We did it, incidentally, in what I thought was a very genuine compromise by Dr. Coburn, who opposed the Affordable Care Act, by referring to the Affordable Care Act and saying, at every point that we raise by 2 months the age of eligibility for Medicare, the eligibility for access under the Affordable Care Act also goes up 2 months. So you are giving people essentially a floor or an alternative to what they have now.

The bottom line here is that this must be done and it can be done. And if you and your colleagues in both parties, both houses can get together with that same spirit as——and Dr. Coburn and I always used to say, when people from different interest groups would come, as they have and will to you, and say, "You can't do this," we would always say to ourselves, privately of course, Tom, Joe, we have to think of our grandchildren. In other words, is Medicare going to be around for our grandchildren? And is the country going to be cutting back the debt so that they are not paying unreasonable parts of their income in Federal taxes or losing some of the basic benefits that government gives? Because our successors in Congress will have no choice but to cut Federal spending in discretionary programs to sustain Medicare.

Bottom line, you have heard before, is that the only way to save Medicare is to change it, to reform it. And I think this is a committee where that can begin, and, ironically, the SGR repeal can be the occasion for doing that. I think you have the opportunity to confound the skeptics who don't believe this Congress can do that.

Neither Democrats nor Republicans nor the administration will get all of what anybody wants in a final bill, if you get to a final bill, but you will get something much more important, which is a solution to a big problem, a real problem. And that, I think, is what the American people want of this Congress more than anything else.

Thank you very much.

[The prepared statement of Mr. Lieberman follows:]

Testimony Before the House Committee on Energy and Commerce

Health Subcommittee Hearing

"A Permanent Solution to the SGR: The Time Is Now"

The Honorable Joseph I. Lieberman, Former United States Senator

Wednesday, January 21, 2015 at 10:15am

2322 Rayburn House Office Building

Testimony of the Honorable Joseph I. Lieberman
House Committee on Energy and Commerce
Health Subcommittee
Wednesday, January 21, 2015

Good morning. Chairman Pitts, Ranking Member Pallone, and members of the Committee. Thank you for the opportunity to testify before this committee on the issue of Medicare's physician reimbursement formula known as the Sustainable Growth Rate, or "SGR."

The Committee is here today to start taking what we all hope will be the final steps in Congress repealing the broken payment formula, the SGR. The members of this committee deserve a lot credit for working last Congress with their colleagues on other committees here in the House, and in the Senate, to forge a bipartisan bill to finally scrap the SGR and lay a foundation for better payment formulas to replace it. As someone who was perennially plagued by the SGR when I was in the Senate, my hat is off to members on both sides of the aisle, on both sides of the Hill, who rolled up their sleeves and achieved consensus on the bill to repeal the SGR.

We know too well the problem with the SGR. Created back in 1997 by Congress, the aim of the payment formula may have been laudable: to curb federal spending by restraining the growth of Medicare's reimbursements to physicians. Unfortunately, the crude budget cap did little to incentivize efficient provider or

patient behaviors. So, since 2002, Congress has routinely intervened to prevent cuts scheduled under the law, passing so-called "doc-fix" legislation, so physicians who provide care for Medicare beneficiaries continue to receive adequate reimbursement. Without repeated Congressional intervention, Medicare reimbursements would be dramatically reduced, threatening the quality and breadth of millions of seniors' access to care.

Today marks a critical juncture in the work of this Committee to pass SGR reform legislation. There has been bipartisan, bicameral agreement on the SGR policy. Now Congress must decide how to address the issue of the approximately $140 billion price tag of the legislation.

As is usual, there are a range of opinions in Congress on this issue. Some in Congress do not believe the estimated $140 billion cost of the bill needs to be offset. The SGR cost is just "funny money," so the argument goes—bad math due to years of temporary patches.

However, I find it interesting to note that, according to an analysis by the Center for a Responsible Federal Budget (CRFB), since 2004, Congress has offset 120 out of the 123 months of doc fixes with equivalent savings—98 percent of the time. As CFRB says, "even ignoring the couple times small gimmicks were used,

policymakers still paid for these delays 95 percent of the time – with almost all of those savings coming from health care programs."[1]

More importantly, according to the Congressional Budget Office, if the SGR bill is not offset, it will increase the nation's deficit. And while there are a lot of issues Congress may disagree on, we should be able to agree that we cannot keep spending money we don't have while charging growing debts to our national credit card.

Today our national debt stands at $18 trillion. The Congressional Budget Office has warned that continued deficit spending could eventually lead to reduced economic output, reduced household incomes, reduced discretionary spending on other important priorities, and even increase the chance of another sudden fiscal crisis.[2]

So now members of this Committee need to finish their work by figuring out how to pay for the SGR bill. I know discussions over offsets can sometimes be tense. During my service in the U.S. Senate, I certainly disagreed –with members of both parties—on any number of "pay-fors" over time.

So, in the spirit of being constructive and supportive of Congress' work on the SGR, I am here today to offer my perspective on policies that could be adopted

[1] http://crfb.org/blogs/actually-sgr-has-slowed-health-care-cost-growth
[2] https://www.cbo.gov/sites/default/files/45471-LongTermBudgetOutlook_7-29.pdf

as a possible path forward. These ideas are based on a Medicare proposal I introduced in the summer of 2011 with former U.S. Senator Tom Coburn.

As I have reviewed the bipartisan, bicameral agreement on SGR reform, I find that it adopts some new policies that are consistent some of our thinking behind the Lieberman-Coburn Medicare reform plan. While our proposal did not permanently scrap the SGR, it did allocate savings to provide a three-year "bridge" toward a new payment models. At the time we said three years was enough time for Congress to develop proposals to replace the SGR. Little did we realize how accurate that estimation would be at the time. So, while the policies Tom Coburn and I outlined could provide some of savings necessary to pay for the SGR reform, the SGR reform agreement could also serve as a platform from which to move naturally to larger Medicare reform that will strengthen the program for years to come.

There are a lot of issues that Tom Coburn and I disagreed on; but there are two bigger things we agreed on that brought us together. First, we both loved our country and saw that it was heading over a fiscal cliff unless people like us came together to get our government's books back in balance. Second, we both loved our children and grandchildren and didn't want to leave our country to them in such an economic mess that they would not have the same opportunities we had,

growing up in America. So Senator Coburn and I put forward a proposal which would have preserved Medicare for current and future seniors.

One reason we offered a package of Medicare reforms was that the biggest structural drivers of our national debt are entitlements, including Medicare. In FY 2015, gross spending on Medicare totaled $605.9 billion as Medicare provided coverage to 55 million individuals who are 65 or older, disabled, or have end-stage renal disease.[3] According to CBO, Medicare's spending will continue to climb over the coming decade—totaling well over $1 trillion just in 2024—while the number of Baby Boomers enrolled swells by a third.[4] At the same time, each Medicare beneficiary will, on the average, take almost three times more out in Medicare benefits than they put in to the system in payroll taxes and premiums.[5]

If we do nothing, Medicare's continued mandatory spending will consume more and more general revenue, as Parts B and D (doctor's services and prescription drugs) will continue to drain increasingly large and unacceptable amounts from our federal treasury, adding to our already-enormous debt. This will also crowd out federal spending on important discretionary programs. And at some point in the next decade, Medicare's Hospital Insurance Trust Fund will be insolvent. Each year, the actual date of anticipated of the HI Trust Fund's

[3] http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf
[4] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf
[5] http://www.washingtonpost.com/wp-dyn/content/article/2011/01/02/AR2011010203213.html, http://www.urban.org/UploadedPDF/412945-Social-Security-and-Medicare-Taxes-and-Benefits-over-a-Lifetime.pdf

insolvency moves slightly closer or farther away, as the models used by CBO and the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) are very sensitive to small changes in the baseline or in base assumptions. But arguing about when Medicare's trust fund is going to be insolvent is a little like arguing over the speed of an oncoming tidal wave—speed is relevant, but it's the scope and direction of the problem that determines the outcome. That's why the status quo in Medicare cannot continue.

Therefore, Medicare reforms are not only important, they are necessary and lead to two tough but unavoidable conclusions. First, we can't balance our budget without dealing with mandatory spending programs like Medicare. Second, we can only save Medicare if we change it. The status quo is unsustainable.

So I offer some specific ideas from our proposal which can help pay for the costs of this needed change to Medicare – fixing the broken SGR formula. I should stress that, while Senator Coburn and I offered our proposal as a coherent whole, our blueprint includes a number of policies and reforms which Congress could chose to adopt and *modify* to help pay for the SGR bill. Our proposal asked just about everyone to give something to help preserve Medicare. But the effects were significant. According to the Office of the Actuary at CMS, the reforms we proposed could save Medicare more than $535 billion and extend the solvency of Medicare for the foreseeable future.

Benefit Modernization. The Medicare benefit structure has long been criticized for being too complex and for promoting overutilization, which wastes taxpayers' money. Within the current Medicare system, cost-sharing such as copays and deductibles vary significantly depending on the type of service provided. Building on a recommendation from the President's fiscal commission, our proposal would streamline Medicare into a single combined annual deductible of $550 for both Part A and B services. Streamlining the deductibles would make it easier for seniors to navigate Medicare while also directly reducing overutilization.

The proposal would also add an annual "out-of-pocket maximum" of $7,500 so that each Medicare recipient would have a cap on annual medical costs to protect them from financial hardship or bankruptcy in the event of a major illness. Medicare enrollees do not have this protection now. That means that, if our proposal were adopted, for the first time in history, seniors would be protected from paying more than $7,500 out of their pockets for health care in any one year because of a serious medical crisis or long term illness. This maximum out-of-pocket protection is the reason most Americans buy health insurance – so they are protected against the financial costs of a devastating illness or disease. Yet, it's a shame that basic Medicare does not offer seniors this peace of mind. There's no reason Congress shouldn't change that.

Medigap Reforms. Today, roughly one in five Medicare enrollees obtain supplemental coverage known as a "Medigap" policy to pay deductibles and copays. Most seniors buy these policies because of the lack of maximum out-of-pocket protection I mentioned previously. Because Medigap plans cover all of the "gaps" in an enrollee's Medicare coverage, policyholders use up to 25% more services than Medicare participants who have no supplemental coverage, even though numerous studies have indicated that this increase in utilization does not lead to better health care outcomes.[6] And because enrollees are only liable for a small portion of this increase in utilization, it is taxpayers – through Medicare costs – and not Medigap insurers who bear most of the costs that result from the increased utilization. Federal costs for Medicare could be reduced significantly if Medigap plans were restructured so that policyholders faced *minimal* cost-sharing for all Medicare services. So, similar to the recommendation from the President's fiscal commission, our proposal would bar Medigap policies from paying any of the first $550 of an enrollee's cost-sharing liabilities and would limit coverage to half of the remaining coinsurance up to the newly created $7,500 max out-of-pocket.[7]

Let me address some objections I have heard to this particular policy. Some worry that changing Medigap plan offerings removes a choice from beneficiaries.

[6] Sample literature: https://www.fas.org/sgp/crs/misc/R42745.pdf, http://www.gao.gov/products/GAO-13-811
[7] Citing original Lieberman-Coburn materials.

Actually, by modernizing the Medicare benefit, Congress would be giving seniors a better choice in traditional Medicare. Others worry about how such changes would impact lower-income beneficiaries. They say that changing first-dollar cost-sharing could harm low-income beneficiaries by allowing them to face greater cost-sharing. However, as mentioned, in addition to the low-income protections that eligible seniors would enjoy, all seniors in traditional Medicare would benefit from more predictable and transparent cost-sharing. Because they would have a maximum out-of-pocket protection, they would not need to buy an expensive Medigap policy to enjoy peace of mind and financial stability. In fact, a 2011 Kaiser Family Foundation analysis released after our proposal was introduced found that Medigap reforms similar to ours would have a profound effect on seniors' pocketbooks in a positive way.[8] Kaiser estimated that roughly four out of five seniors would save money with Medigap reforms, and some seniors would save more than $1,000 a year from this change. I'd challenge anyone to come up with a policy which saves the Medicare program and also reduces costs for 80% of seniors! Moreover, the study also found that even if insurers did not pass the full amount of savings directly to seniors, or if seniors didn't make notable behavioral changes, the policy would still substantially save seniors and the program money.

[8] http://kff.org/medicare/report/potential-effects-of-medigap-reforms

Increasing Income-Related Premiums. Our proposal required higher income Americans to pay more for their share of Medicare Parts A, B and D. For Medicare Parts B and D, we asked the wealthiest Americans to pay 100 percent of *premium* cost. I do not believe tax dollars should be used to pay premiums for those who can afford to pay on their own. For example, according to data the Social Security Administration shared with Dr. Coburn, there are more than 60,000 seniors enrolled in Medicare with annual income at or above $1 million. With Medicare facing a financial crisis, why should we subsidize their premiums? Our policy would allow the wealthiest seniors to remain in the program, but they would be responsible for the full share of their premiums.

Eligibility Age. The eligibility age for Medicare benefits is 65, although certain people qualify for coverage earlier because of disability. Since the creation of the Medicare program in 1965, life expectancy and the average length of time that people are covered by Medicare has risen dramatically. According to the Centers for Disease Control, when Medicare was passed in 1965, the average lifespan for Americans was 70.2. In 2006, the average lifespan for Americans was 77.7 – an increase of 10.6%.[9] This increase in the length of time an enrollee may be covered by Medicare has significantly raised the costs of the overall program. Our proposal would increase the eligibility age for Medicare over a 12 year period from 65 to 67

[9] Citing original Lieberman-Coburn materials.

to reflect gains in life expectancy, which has increased since 1965, from about 70 to just under 78 now. Under our plan, as the eligibility age increased two months each year, so too would the access to the exchanges created under the ACA. The eventual eligibility age of 77 has been viewed by some as a radical change to Medicare. But the greatest threat to Medicare is not reform; it's the status quo. I also find it interesting that some critics disparage moving the age to 77, even though that would mirror the eligibility age of Social Security. A survey from Gallup last year found that one in four seniors over age 65 are still employed.[10] A similar survey in 2013 found that fully three-quarters of workers anticipate working past the retirement age.[11] Importantly, adopting this particular reform would not change the benefit for a single senior – but it could help save the program for the millions of seniors to come.

Aligning Premiums With Value. Medicare Part B allows seniors to purchase insurance coverage for physicians' and other outpatient services for a set monthly premium. When the program began in 1966, the premium was intended to finance 50% of Part B costs per aged enrollee with the remainder funded by the federal government. President Lyndon Johnson noted this 50/50 cost share in his speech when he signed Medicare into law saying, "And under a separate plan, when you are 65 you may be covered for medical and surgical fees whether you are in or out

[10] http://www.gallup.com/poll/165470/end-recession-seniors-workforce.aspx
[11] http://www.gallup.com/poll/162758/three-four-workers-plan-work-past-retirement-age.aspx

of the hospital. You will pay $3 per month after you are 65 and your Government will contribute an equal amount."[12]

Subsequent legislation has reduced that share and premium collections fell to less than 25% of program revenues in the early 1990s. The Balanced Budget Act of 1997 permanently set the Part B premium at about 25% of Part B costs per aged enrollee. General revenues still fund the remaining 75% of Medicare Part B, which puts enormous pressure on the federal budget year over year. In 2011, the majority of Medicare enrollees paid a premium of $96.40 per month.

Our proposal would raise the basic Part B premium for all enrollees by 2% of program costs every year for five years until the premium level enrollees paid reached a minimum level of 35% of the program's cost in 2019. The dollar amount of the monthly premium increase per year would be, on average, approximately just $15-20 a month. While this particular reform may be seen as a non-starter for some, this policy could easily be modified so that only new beneficiaries enrolling in the program would face higher premiums.

I know the conventional wisdom suggests that Congress will never change Medicare premiums or cost-sharing until the program's financial status is in a much more dire state. But I believe there is a small cluster of benefit modernization reforms and premium changes which are not only sound policy; I believe these

[12] http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp

policies can improve the basic Medicare benefit for millions of Americans. I also think a number of reforms in this area win bipartisan support. The President's fiscal commission endorsed similar reforms.[13] For example, in his FY 2015 Budget, President Obama endorsed policies which would:

- Increase income-related premium under Medicare Parts B and D, and;
- Modify Part B deductible for new enrollees, and;
- Introduce a Part B premium surcharge for new enrollees who purchase near first-dollar Medigap coverage.[14]

Now I encourage members of this Committee to build on the good bipartisan foundation they laid by continuing to work with their colleagues in exploring a range of policies in this area. I realize that some provisions will make some group of people unhappy and provide targets to attack. But as we have discussed: the SGR status quo is broken, and the overall status quo in Medicare will lead to insolvency and fiscal turmoil for the federal budget. The most compassionate thing members can do is act now to fix SGR and adopt some common-sense reforms – not punt on these issues to another Congress for another day. As a former legislator, I realize that adopting reform policies will require courage and cooperation. But these reforms not only strengthen the Medicare program and improve the benefit by making it more fair and predictable, they can be modified

[13] http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf
[14] https://www.cbo.gov/sites/default/files/45250-Health_Programs_Proposals.pdf

and adjusted as needed, as members seek to build a balanced package of reforms to offset the SGR. So if there is a failure to agree on policies as offsets and pay for SGR reform, it will not be a failure of policy options or lack of needed analysis; it would be a failure of bipartisan will to succeed.

In closing, let us reflect on the fact that the Medicare program will turn 50 years-old this summer. This critical program has provided needed health care to millions of Americans over the past five decades. But Congress needs to act now to adopt targeted policies – like fixing the SGR and paying for it with solid reforms—if the program is going to be strengthened and sustained for the next 50 years. Medicare's financing problems didn't emerge overnight, and they won't be fixed in a single bill. But the SGR reform bill presents members of the committee and members of this Congress with a truly historic opportunity to take a solid step forward in fixing Medicare's larger financing problems while eliminating the "doc-fix."

I realize reform-minded members are facing entrenched conventional wisdom betting that Congress and the President won't be able to reach an agreement, and will be forced to temporarily patch the program later this spring. But there's no reason Congress and the president can't prove the cynics wrong. You have already proven it's possible to forge a bipartisan agreement to solve the SGR problem. Now what is needed is a willingness to sit down and work together in coming

weeks to agree to offsets which can pass both chambers of Congress. Neither Democrats, nor Republicans, nor the Administration might get exactly what they want in a final bill. But working together, you can show the American people that it is possible to tackle big problems while adopting meaningful solutions that get our government's books more in balance and strengthen the Medicare program.

Mr. PITTS. The chair thanks the gentleman and now recognizes Dr. Rivlin, 5 minutes, for summary of her testimony.

STATEMENT OF ALICE RIVLIN, PH.D.

Ms. RIVLIN. Thank you, Mr. Chairman.

I, too, am delighted that this committee is holding this hearing. I think you have a historic opportunity to do two things at once: You can replace the Medicare sustainable growth rate and halt this unfortunate budgetary practice of kicking it down the road every year, and at the same time you can begin phasing in new payment incentives that will nudge Medicare and, indeed, I believe, the whole health system toward high-quality, more cost-effective delivery of care.

I would like to make four brief points.

First, the point you have made yourself and others have made, the SGR should be fixed permanently. This formula, with its pending 20 percent or thereabouts cut in Medicare physician fee schedule payments, just creates unnecessary uncertainty for doctors and their patients. Keeping the formula in the law but postponing its impact every year just makes our legislative process look ridiculous.

Second, replacing the SGR can advance payment reform. It can move the healthcare delivery system away from fee-for-service, which is still very prevalent in Medicare, which rewards volume rather than value, and move it toward higher quality and less waste. And that is good for everybody, especially beneficiaries of Medicare.

Now, the tri-committee bill that you have spoken of, Dr. Burgess' authored bill, is a very promising approach and does just that. It proposes that future Medicare payment rate updates for physician fee schedule providers be contingent on participation in alternative payment mechanisms beginning in 2023.

This bill is a good foundation, but we and many others think it could be strengthened. My colleagues at the Bipartisan Policy Center are releasing two papers today, which I believe you all have, which recommend accelerating the introduction of higher payments for providers that participate in alternative payment mechanisms from 2023 to 2018——you don't need to wait that long——and applying the incentives to all Medicare providers.

Other recommendations involve other alternative payment mechanisms and, particularly, strengthening accountable care organizations and relating the updates to the amount of risk that they are willing to take on.

These changes could alleviate many of the challenges that providers are struggling with today as they work to implement new models of care.

Now, payment reform is still a work in progress, with many details to be developed. Nevertheless, Congress can develop, at this point, a roadmap that will give providers more certainty that it is worth investing in the infrastructure necessary to develop alternative payment mechanisms and that the future of healthcare delivery is rooted in shifting to new models of care. These types of reform, I believe, have the most potential to deliver on the promise

of improved healthcare delivery that should be at the heart of every SGR fix.

Bipartisan Policy Center is not alone in proposing the various ways of strengthening the bipartisan bill. My colleagues at the Brookings Institution have a set. We strongly endorse the thrust of the bill but urge beefing it up in many dimensions. And we are very happy to supply more information on that subject.

Third, I believe that the SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health spending appear less daunting than it did in the past. Nevertheless, Medicare spending under the new payment model would be higher, about $144 billion higher over 10 years and more if you include Medicare extenders, than under the present SGR formula. That must be offset. The Congress should not set a precedent of not paying for anything, but especially not for a reform like SGR.

But paying for the SGR is also an opportunity to find offsets that are also good health policy. There are a whole bunch of lists of such offsets, and I don't have time to go into them here orally, but I have referenced them in my testimony. And I think there are a sufficient number of quite plausible offsets, that the Congress should not have trouble finding a good set.

That being said, if you have too much difficulty finding offsets, which will clearly be a heavy lift, we do have a suggestion for a semipermanent fix, working with 5 years instead of 10, which might be a helpful way out of that dilemma.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Rivlin follows:]

Testimony of
Alice M. Rivlin
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Co-Chair, Delivery System Reform Initiative
Bipartisan Policy Center

U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health Hearing on
"A Permanent Solution to the SGR: The Time is Now"

January 21, 2015

Chairman Pitts, Ranking Member Green: I am delighted to participate in this hearing and commend you for diving into such a complex subject so early in the congressional session. This committee has the rare opportunity of restarting a bipartisan process, which can accomplish two important goals at once. You can replace the Medicare Sustainable Growth Rate (SGR) physician payment formula, thereby halting the unfortunate budgetary practice of creating an expensive temporary patch on the formula every year. At the same time, you can begin phasing in new payment incentives that will nudge Medicare and, indeed, the whole health delivery system, toward high-quality, more cost-effective delivery of care.

The SGR should be fixed—permanently. Bipartisan, bicameral cooperation can solve a problem that everyone wants solved. The SGR formula, with its pending 21 percent cut to Medicare physician-fee-schedule payments, creates unnecessary uncertainty for Medicare providers. Keeping the formula in the law but postponing its impact every year makes our legislative process look ridiculous. Now is the time to stop kicking this problem down the road and get it fixed.

Replacing the SGR can advance payment reform. It can move health care delivery away from fee-for-service (FFS), which rewards volume rather than value, and toward higher quality and less waste. The tri-committee bill from 2014 included promising approaches to do just that, especially by proposing that future Medicare payment rate updates for physician-fee-schedule providers be contingent on participation in Alternative Payment Models (APMs) beginning in 2023. The tri-committee bill provides a good

foundation that can be strengthened. For example, my colleagues at the Bipartisan Policy Center (BPC) are releasing two papers today, which recommend accelerating the introduction of higher payments for providers that participate in alternative payment mechanisms (APMs) to 2018, and applying the incentives to all Medicare providers. The recommendations also include encouraging the transition to organized systems of care by making patient-centered medical homes (PCMHs) available nationwide and counting them as APMs. BPC recommends developing bundled payment as an APM to engage specialists in payment reform and enhance provider experience in partnering with other providers and sharing risk. BPC also recommends strengthening Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) by adopting (1) prospective benchmarks, (2) prospective attribution, (3) a smaller set of quality measures more focused on patient health outcomes, (4) a patient-choice model that better engages beneficiaries in their care, and (5) a more viable pathway to taking on risk for spending and outcomes, including a transition from historical benchmarks to regional, risk-adjusted benchmarks.[1]

These changes could alleviate many challenges that providers are struggling with today as they work to implement new models of care. For instance, "historical" or after-the-fact attribution of beneficiaries to an ACO makes it difficult for providers to know and be accountable for the population of patients they serve. Resetting ACO benchmarks every contract period may make the task of reducing cost and improving quality continuously too hard for providers to sustain. The long-term promise of these models won't be realized if unrealistic short-term pressures for savings make it unlikely that many providers can succeed. These are all fixable problems that can be addressed as part of SGR reform.

Payment reform is still a work-in-progress with many details to be developed. Nevertheless, Congress can develop a road map that gives providers more certainty that it is worth investing in the infrastructure necessary to develop APMs, and that the future of health care delivery is rooted in new models of care.

[1] Bipartisan Policy Center, *Transitioning to Organized Systems of Care*, "Medical Homes, Payment Bundles, and the Role of Fee-for-Service;" and "Near-Term Recommendations to Improve Accountable Care Organizations in Medicare." January 21, 2015.

These types of reforms have the most potential to deliver on the promise of improved healthcare delivery and should be at the heart of any SGR fix.

BPC is not alone in suggesting strengthening the tri-committee bill. In November, 2013, several of my Brooking colleagues and I submitted comments to the Senate Finance Committee on the proposed SGR Repeal and Medicare physician payment reform.[2] We strongly endorsed the basic thrust of the tri-committee bill and urged beefing it up in several dimensions. We recommended decoupling value-based payments (VPB) from fee-for-service payments. If VBP payments are add-ons to the physicians FFS payment, they risk intensifying the incentive to increase the volume of services rather than reducing it. We urged greater clarity in defining eligible APMs and up-front bonus payments to help physicians handle the initial costs of revamping the way they practice. We also supported accelerated development of APMs, introducing additional payment reforms, such as bundled payments for post-acute care, more aggressive efforts to develop and use improved performance measures, and delivery of more timely Medicare beneficiary data to physicians to help them track their performance and identify opportunities for improvement.

SGR reform must not add to future deficits. Cost growth in health care has slowed in recent years, which makes projected health care spending appear less daunting than it has in the past. Nevertheless, Medicare spending under a new payment model would be higher—about $144 billion higher over ten years (more if the Medicare extenders are included) than under the current, unrealistic SGR formula. Fixing the SGR must be paid for – that's just good budgeting. Congress should not establish a bad precedent by yielding to the temptation to waive the PayGo rules just to make it easier to get something as important as fixing the SGR done.

Paying for SGR is also an opportunity to find offsets that also demonstrate good health policy. Out of the many proposals for reforming health care it should be possible to put together a balanced set of

[2] Fontenot, et al. "Comment on Proposed SGR Repeal and Medicare Physician Payment Formula." The Brookings Institution, November 12, 2013. http://www.brookings.edu/research/opinions/2013/11/12-medicare-physician-payment-reform

savings sufficient to offset the projected ten year costs of replacing the SGR with payments more likely to reward health care value.

In February, 2014, my colleagues at Brookings and I offered a list of reforms that we thought would move health care delivery toward more cost-effective spending and provide savings to offset the cost of repealing and replacing the SGR.[3] These included reforming Medicare supplemental insurance to eliminate first dollar coverage; creating a single deductible and an out-of pocket limit for hospital and ambulatory care (Parts A and B) and modifying Medicare copayments; using competitive bidding to set payments and improve quality, starting with lab tests; rewarding beneficiaries for using generic drugs; raising the Medicare premium for higher income individuals; paying for post-acute care in the setting most appropriate to the patient's needs (not necessarily where the acute care occurred); and several others.

In November, 2014, the non-partisan Committee for a Responsible Federal Budget, on whose board I serve, released a comprehensive list of offsets that are designed to reduce health spending and bend the cost curve. These include many similar proposals, including encouraging the use of generic drugs, modernizing the Medicare Parts A and B cost-sharing rules, expanding the use of bundled payments; and restricting first dollar coverage in Medigap plans.[4]

In fixing the SGR and finding ways of paying for it, it is important to keep in mind the larger context of Medicare reform; it is a vital program upon which millions of seniors and people with disabilities depend on for health care. It must be preserved, strengthened, and modernized. In 2013, I joined former senators Pete Domenici, Tom Daschle and Bill Frist at the Bipartisan Policy Center in developing a set of recommendations to modernize the basic Medicare benefit and accelerate payment and delivery reforms.[5] Included in this report are a variety of proposals that we believe would not only reduce costs, or at least

[3] McClellan, M. Rivlin, A., Fontenot, K. "Paying for a Permanent, or Semi-Permanent, Medicare Physician Payment Fix." *Health Affairs*. February 2014. http://healthaffairs.org/blog/2014/02/14/paying-for-a-permanent-or-semi-permanent-medicare-physician-payment-fix/

[4] The Committee for a Responsible Budget. "The Prep Plan: Paying for Reform and Extension Policies." November 17, 2014. http://crfb.org/document/prep-plan-paying-reform-and-extension-policies.

[5] Rivlin, A. Frist, B. Domenici, P., Daschle, T. Bipartisan Policy Center. "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment." Bipartisan Policy Center. April 2013. http://bipartisanpolicy.org/library/health-care-cost-containment/

not increase them, but also improve the Medicare program for beneficiaries. Let me share just a few examples:

- We developed a budget-neutral reform of Medicare's beneficiary cost-sharing, which would combine the Part A and Part B deductibles, but also give all beneficiaries new protection against catastrophic out-of-pocket costs and ensure that all beneficiaries could see a doctor for only a copayment, even if the combined deductible isn't yet met.
- We proposed to limit supplemental coverage, expand income-related premiums, and then invest a portion of the savings in providing new cost-sharing assistance to low-income beneficiaries who are near-poverty. These changes also relate to our proposal to allow providers who participate in APMs – or what we called Medicare Networks – to offer incentives (such as primary care cost-sharing discounts) to patients to improve care coordination, patient choice, and engagement.
- We suggested ways to create stronger incentives for beneficiaries of the Part D Low-Income Subsidy to use high-quality, lower-cost drugs, when available.

As these overlapping lists make clear, responsible non-partisan health policy analysts have worked hard to identify reforms that would offset the cost of SGR repeal and there is considerable convergence in their views. Not everyone who has endorsed a package of offsets would defend all of the component parts individually. Cutting spending is always difficult and compromises are necessary to reach an agreement. But is should be possible for Congress to agree on a balanced list of offsets that are consistent with moving toward more cost-effective delivery.

That being said, finding sufficient offsets will be a heavy lift and it may prove impossible to find enough. In that situation, a semi-permanent fix, as my Brookings colleagues and I termed it, would be far better than another one-year patch.

A semi-permanent fix could include a five-year period of payment stability, which would cost roughly $50 to 60 billion, and it should be paired with the structural reforms we discussed earlier – giving

physician-fee-schedule providers stronger incentives to participate in APMs and strengthening the new payment models themselves. One policy option that has been included in Democratic and Republican congressional budget proposals, as well as administration budget proposals, is an expansion of income-related premiums for higher-income Medicare beneficiaries. That alone could pay for a semi-permanent fix, while putting the health care system on a course of greater quality and efficiency for all beneficiaries and taxpayers.

Mr. Chairman and members of the Committee, we are at a critical juncture in health care. While cost growth has come down a great deal, we have experienced similar declines in the past only to see another round of rapid cost growth follow on its heels. It is absolutely critical that we keep the momentum going on health reform by demonstrating concretely to health care providers our commitment to move away from our current, antiquated, fee-for-service payment models in Federal programs. The single most important thing we can do as the Federal government is set this as a clear direction in Medicare, and the proposals you are now considering can move us in that direction.

Thank you again for the opportunity to share my thoughts on the SGR, payment reform, and our health care system. SGR is a tough problem, but it's an even bigger opportunity for the country. I urge all of the members of the committee, majority and minority, to work together to fix it this year. On behalf of my colleagues at BPC and Brookings, we look forward to continued dialogue and helping however we can.

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The views expressed in this piece are those of the author and should not be attributed to the staff, officers or trustees of the Brookings Institution or the Bipartisan Policy Center.

Mr. PITTS. The chair thanks the gentlelady and now recognizes Dr. Moon, 5 minutes, for her summary.

STATEMENT OF MARILYN MOON, PH.D.

Ms. MOON. Thank you, Mr. Chairman.

I am very pleased to be here today to testify. This is an area that I feel very strongly about. All of my research for many years, from initially working with Dr. Rivlin at CBO until today, has focused a lot, most of it, on beneficiary issues, protecting beneficiaries in the Medicare program. And that is where I am going to focus my testimony today.

Eliminating the sustainable growth rate under Medicare would constitute a major policy improvement. And I believe that the instability in payment toward physicians and the contribution that that has made toward the many physicians opting out of the program is a serious problem for beneficiaries and qualifies, itself, as a beneficiary issue as well as an important payment issue for physicians.

But I am concerned about the whole issue of offsets, and that is where I am going to spend most of my time today. There is a sense that there needs to be an offset to pay for this policy change, but I would point out that there is nothing about Medicare's stability that requires that Part B changes be covered by benefit cuts elsewhere. And that, I think, is a very important concept.

Nonetheless, many of the SGR reform proposals are paired with changes in Medicare at the expense of beneficiaries. If offsets are deemed essential, a reasonable alternative would be to look for policies across the Federal Government that are similarly unwise for which repeal could generate savings and, in many cases, represent the same kind of poor policy that has been recognized over time but not dealt with.

Part of the justification for focusing on Medicare, however, stems from the notion that the program is too large or out of control. But I would point out that Medicare's per-capita growth rates have been less than the rates of growth in the private insurance world for more than 40 years. Medicare has simply done a better job than the private healthcare sector in controlling costs over time.

And another source of growth in Medicare that causes people sometimes to be concerned about the program is the increase in the number of beneficiaries, to this point largely caused by an increase in life expectancy——again, a success story for Medicare, not something for which Medicare should be condemned.

Finally, the rate of growth in spending on Medicare has declined in recent years. Efforts to introduce new ways to control costs seem to be working. And, indeed, building the SGR change on top of some of those promising reforms, as is part of your legislation that has been considered, is a good idea.

But most of the major reform options being discussed for reducing Medicare spending focus on increasing the share that beneficiaries pay or reducing the number of people eligible. Since people must still get care somewhere, such options are essentially ways of asking beneficiaries to pay more.

Medicare is in no way, however, an overly generous program. Medicare pays only about 70 percent of the costs of just the serv-

ices it covers, forgetting the other things like vision and dental and other things that Medicare does not cover. Beneficiaries or their families or former employers are responsible for the remainder.

And just as costs to the Federal Government have risen over time, so have the costs to beneficiaries. Beneficiaries' incomes have certainly not kept up with the increased costs in healthcare spending that they must themselves undertake over time.

And the problem is particularly severe for those with modest incomes whose resources keep them above eligibility for Medicaid or special low-income protections but low enough to make it difficult to afford care.

One of the most urgent areas of need is for better low- and moderate-income protections for Medicare beneficiaries, not increasing their burdens. Yet some of the proposals that even seem to be more neutral or across-the-board can have unintended consequences that harm beneficiaries, particularly these more vulnerable ones.

For example, raising the age of eligibility is something that often sounds good, usually to people like me who like to continue working well past the age of eligibility. But for lower-income individuals who have poor skills and poor health, that simply is a major cut in benefits, and it is a major problem for those beneficiaries.

Similarly, raising the premiums to beneficiaries over time would cast an enormous burden on, for example, a woman who is earning just above the paltry level that Medicare provides special benefits for of $18,000 a year, raising her out-of-pocket costs from about 15 percent of her income to 17 percent of her income——certainly not moving in the right direction in terms of the changes.

So I believe that it is important to recognize that any fix to the SGR that raises Medicare spending will also result in higher costs to beneficiaries when the payments to physicians rise. Beneficiaries will pay more by any fix that you do to the SGR because we are going to increase payments to physicians.

The sustainable growth rate is poor public policy and ought to be fixed, but beneficiaries, I believe, should not be penalized for the poor policymaking that occurred so many years ago.

Thank you.

Mr. PITTS. The chair thanks the gentlelady.

[The prepared statement of Ms. Moon follows:]

Fixing the SGR While Protecting Medicare Beneficiaries

Testimony by

Marilyn Moon

American Institutes for Research

January 21, 2015

Presented to the Subcommittee on Health

Committee on Energy and Commerce

House of Representatives

Congress of the United States

Summary

Fixing the flawed Sustainable Growth Rate makes good policy sense. It is important to have a reasonable payment policy for physicians that does not penalize them over time.

But the appropriate tradeoff for an SGR fix is not policy that harms Medicare beneficiaries on the claim of a need for budgetary offsets. There is no compelling need to reduce benefits to Medicare beneficiaries. Medicare is not a runaway program in need of reform.

Most of the proposals for Medicare savings would increase an already heavy burden on Medicare beneficiaries in the form of higher costs or poor access to services.

- Beneficiaries already pay a very large share of their incomes towards the costs of care that Medicare does not cover.
- Many proposals—even increasing the eligibility age that seems to be applied across-the-board—would fall disproportionately on low and moderate income individuals.
- It would be beneficial to pair improvements in the SGR with better low income protections as has been part of past proposals.

Budgetary offsets, if desired as part of a package, could come from sources beyond Medicare.

- If Medicare needs to be placed on a stronger financial footing, new sources of revenue for the program should be part of the discussion about Medicare's future.
- Closing tax loopholes or cutting other programs that are not performing as intended would be a more appropriate strategy for offsetting costs of the SGR.

Statement of Marilyn Moon

Eliminating the Sustainable Growth Rate (SGR) under Medicare would constitute a major policy improvement. The SGR is widely recognized as a flawed policy; there is strong agreement that the limits it sets are too stringent and treat physicians unfairly. So far, however, the most that has been accomplished are short term fixes. The SGR has been modified 18 times since 2002, usually at the last minute. Numerous attempts to generate a permanent fix have stalled because of the cost estimates for doing so. Since technically the SGR is current law, any fix must address the cumulative impact of the formula which means a large budget price tag. Allowing the SGR to take effect would mean more than a 24 percent cut in payments for physicians because the "look back" effectively incorporates 15 years of flawed calculations. But many of the proposals to fix the SGR are often coupled with proposals to severely cut benefits in the Medicare program that would have a detrimental impact on beneficiaries. My testimony today will speak to the issues surrounding how to tackle the problem without making other undesirable policy changes.

Problems Generated by the Sustainable Growth Rate

The SGR has created instability in payment policy toward physicians and likely has contributed to a number of physicians declining to participate in Medicare or in limiting the number of Medicare patients they are willing to see. Critical providers of services to Medicare beneficiaries are threatened periodically with massive cuts in payments; and even when those reductions are eliminated at the last minute, the payment levels have been frozen or allowed to increase only modestly. It is no wonder that many physicians are extremely mistrustful of participating in

Medicare. While defections are not yet widespread, this is a major problem hanging over the program and should not continue.

The intent of the SGR was to provide discipline to the rapid growth in physician payments, but it has never helped with that issue. It is too broadly conceived—penalizing all physicians for growth in physician spending, for example. And other technical problems with the formula penalize physicians for events well beyond their control. Even very conscientious physicians need to find ways to offset the decline in real payments that have occurred over time, resulting in a situation in which the SGR actually encourages adding visits and upcoding to offset other losses. It needs to be replaced with a better mechanism for holding providers of services accountable.

The many activities now underway by CMS in its innovation demonstrations hold considerable promise of tackling the issues of paying for the right care in the right setting. Early indications are that they will help over time with the issue of cost growth in Medicare, and likely improve the incentives that physicians face to provide quality care. Indeed, the recent slowdown in spending is likely attributable in part to the attention drawn to these efforts as well as to the weak economy. Whatever the reason, spending growth in Medicare does not carry the urgency it did just a few years ago. Care and vigilance are necessary, but now is a particularly good time to eliminate a failed policy that promises only to alienate the provider community.

The Demand for Finding Savings to Offset the SGR Fix

Why is there a sense that there needs to be an offset to "pay" for this policy change? In the past, for example, not all of the temporary fixes have been offset by other cuts. And in many ways, this could be viewed as a technical adjustment that does not carry the same weight as introducing new spending policy. And with Medicare's current slow rate of growth, it is appropriate to question why proposals to fix the SGR are tied to cuts in the program.

Historically, a tortured set of offsets to the costs of changing the SGR have been proposed. Usually what happens is only a temporary "fix" since that is not as costly. Why should Medicare beneficiaries be penalized for poor policy decisions made many years ago? If a more reasonable annual update policy had been adopted, there would be no need to find additional "revenues" because each annual update would have been part of the ordinary growth in Part B which, by statute, is covered by general revenues. Nothing about Medicare's stability requires that the Part B change be covered by some type of benefit cuts elsewhere. Nonetheless, once again, the debate includes the issue of how to "pay" for what is in many ways an accounting artifact.

If There Must be Offsets, Why Medicare?

Many of the proposals to eliminate or replace the SGR have been paired with changes in the Medicare program that seek savings—usually at the expense of beneficiaries. Why should this desirable policy change be required to come from Medicare? A reasonable alternative would be to look for policies across the federal government that are similarly unwise for which repeal could generate savings. In the panoply of tax and spending policies, there are many examples. Closing tax loopholes that encourage inappropriate behavior on the part of taxpayers would be a

good source of new revenues for example—and some of them essentially reflect the same type of unintended consequences from legislation or rules that do not work well in practice.

Part of the justification used for finding savings from Medicare is that it is viewed by some as too large. Certainly, Medicare has grown rapidly over time and needs to be examined for potential problems, but size does not automatically make it a desirable target. Health care spending for everyone has grown rapidly since the 1970s, and in fact, Medicare's per capita growth rates have been less than the rates of growth in the private insurance world over more than forty years. Medicare has been more successful at holding the line on spending growth than have other payers. Another source of growth in Medicare is from increases in the number of beneficiaries. Until the recent swelling of enrollees from early Baby Boomers retiring, the reason for per capita growth has largely been the longer life expectancies of older Americans. This is an indication of the success of Medicare and not something to be rated a problem per se. Finally, the rate of growth on spending in Medicare has declined in recent years. Efforts to introduce new ways to control costs seem to be working. For all these reasons, Medicare should not be viewed as a runaway program.

The Problem of Paying for the Fix with Beneficiary Cuts

Beyond innovations to better control what spending occurs, most of the major options being discussed for reducing Medicare spending focus on increasing the share that beneficiaries pay or reducing the number of people eligible. Since people must still get care somewhere, such options are essentially ways of asking beneficiaries to pay more. For example, a higher age of eligibility is essentially a cut in benefits, especially for those who do not have access to

subsidized insurance from employers or the federal government. Higher premiums or co-pays largely shift costs onto beneficiaries. Providing vouchers to purchase private insurance subject to limits on how fast federal subsidies can grow (an option referred to as premium support) is also a way to shift costs and risk onto beneficiaries. And even some of the "efficiencies" that limit access to care may be cost shifts if they do not truly improve the way that care is delivered but rather restrict access to needed services. Thus, most of the reforms under discussion would lower the share the federal government contributes to Medicare's costs.

Are these the best strategies for supporting Medicare into the future? Medicare is in no way an overly generous program in terms of what it covers. Medicare pays only about 70 percent of the costs of the services it covers (and it fails to cover many important services). Beneficiaries (or their families or former employers) are responsible for the remainder. And just as costs to the federal government have risen over time, so have the costs to beneficiaries. They now pay a greater share of their incomes toward the costs of their care than ever before; incomes for all seniors have risen more slowly than the costs of health care that they must pay out of pocket.

And the problem is particularly severe for those with modest incomes whose resources keep them above eligibility for Medicaid or special low income protections, but low enough to make it difficult to afford care. One of the most urgent areas of need is for better low and moderate income protections for Medicare beneficiaries. In fact, often paired with a fix to the SGR has been a proposal to make the Qualified Individual (QI) program--that provides modest low income protections--a permanent part of Medicare. Good policy should actually take this even further, raising the very low limits on who gets aid.

Nonetheless, the proposals tend to move in the opposite direction—taking more out of the incomes of older and disabled Americans. For example, one option often proposed is to raise the Part B and D premiums to 35 percent of the costs of the insurance from their current levels of 25 percent of costs. What does this mean for beneficiaries? A beneficiary with an income of $18,000 per year is not eligible for any low income protections. If such a beneficiary faces the average out of pocket costs experienced by Medicare beneficiaries, that person would currently be spending nearly 15 percent of her income on Medicare (and even more on total healthcare costs). The premium increase of a little over $500 per year would bring that burden to more than 17 percent of her income.

Other proposals sometimes discussed for Medicare would raise the cost sharing requirements, for example, by making home health benefits subject to the same type of requirements for other Part B services. Again, it is essential to consider whether this is sound policy. The users of home health services are among the most vulnerable beneficiaries: they are older and much sicker than on average and hence are less likely to be able to absorb that burden. Moreover, for these types of services, there is little evidence that cost sharing would curb unnecessary use. It is more likely that it would deter access to care for these most vulnerable of beneficiaries.

Raising the age of eligibility is another policy that can have unintended consequences in penalizing those least able to afford health care. Higher income beneficiaries are much more likely to either still be working or to have retiree benefits. Consequently, they would feel little burden. But those who cannot work because of poor health or whose skills make it difficult for

them to remain in the labor force would be the ones most likely penalized by such a change in eligibility. What sounds like an across-the-board change would not be so in practice. Further, raising the age of eligibility saves very little money since most beneficiaries in their mid-60s are healthier than average and tend to hold down the per capita costs of the program. Taking them out of the Medicare pool would result, for example, in higher Part B and D premiums for those who remain—another unintended consequence.

Even the increases aimed at "high income" beneficiaries would be painful for many who have already been asked to pay more out of pocket in recent years. The only way to get substantial savings from this is to continue to penalize those who by any other measure would be considered middle class since the number of truly high income beneficiaries is small.

Finally, it is important to recognize that any fix to the SGR that raises Medicare spending will result in higher costs to beneficiaries when the payments to physicians rise. For example, if costs to the federal government rise by $10 billion, beneficiaries will experience approximately a $2.5 billion increase in required cost sharing. Thus, even with no other policy change, beneficiaries will be paying more.

Other Approaches

As one of the most popular of federal programs, Medicare enjoys enormous support from the public at large. In fact, polling consistently indicates a willingness to pay higher taxes if necessary to support the program. Medicare offers basic insurance to our most vulnerable and needy citizens and does so with considerable efficiency. The design of the program is to reduce

some of the inequality that arises in our economy by providing the same benefits to all who qualify regardless of the amount they have contributed to the program. Thus, when considering what tax increases or spending reductions could be used to pay for the SGR fix, it is important to consider options beyond Medicare.

If it is believed that Medicare is not sufficiently financed, any options under consideration for changing the program should include increasing the revenue stream into the program. Indeed, increasing taxes to support Medicare is consistent with the intent of the program as it was conceived in the 1960s. It was recognized even then that the ratio of workers to retirees would decline over time and that increases in health care spending occurred more rapidly than costs of other goods and services and wages. But the idea of fully funding the system to plan for these changes was rejected since it would create a drag on the economy. Rather, the intent was that tax rates would be adjusted upward periodically to keep the system sound. The growth of the economy—and incomes of workers—were expected to make it possible to fund health care spending for succeeding waves of seniors. Are we in a position today to afford higher contributions? That question is certainly one that should be compared to the issue of whether beneficiaries can afford further cuts in benefits.

Conclusion

The Sustainable Growth Rate is poor public policy and ought to be fixed. But beneficiaries should not be penalized for the poor policy making that occurred fifteen years ago. The SGR should not be used as a rationale for reducing valuable benefits to our most vulnerable citizens.

Mr. PITTS. That concludes the opening statements of our witnesses. I will begin the questioning and recognize myself 5 minutes for that purpose.

Senator Lieberman, you were eloquent in your testimony about the need to pay for the SGR, yet I am concerned that some voices continue to suggest that it need not be offset.

As a practical matter, House leadership has said that a bill must be offset to be put on the floor for a vote. So I fear that Members or organizations who continue to suggest moving SGR without offsets actually are maybe at best not serious or at worst could doom SGR reform to certain defeat.

In your opinion as a former legislator, do you believe that SGR reform can pass this Chamber without offsets?

Mr. LIEBERMAN. Obviously, in the end——thanks, Mr. Chairman——you all will notice and determine it more than I, but my sense, based on the results of the election last November and the stated opinions of those in the majority here and some in the minority, that this extraordinary achievement that began here in the subcommittee, which is to come to a bipartisan agreement on replacing the failed SGR formula, will not make it into reality unless there is an offset.

And, again, there is nothing particularly, based on history here, radical about this. As you said, I believe, Mr. Green, maybe both of you, in 98 percent of the time the doc fixes have been offset for exactly the same reasons that your question raises.

Mr. PITTS. What would your advice be for organizations considering making a push for an unpaid-for SGR bill in this Congress?

Mr. LIEBERMAN. Well, my advice——gratuitous, but you have asked me——is to think of what your goals are. And if you are an organization representing physicians, for instance, and you push for this SGR replacement reform with no offset, the danger is——and it is a high risk——that nothing is going to happen and physicians are going to suffer and, as has been said earlier, people are going to leave the medical profession, patients will suffer. If you are representing beneficiaries, obviously the same is true.

So we have to give a little bit here to preserve the essential system, which is a great system. We are about to come to the 50th, if I am not mistaken, anniversary of Medicare, and it would be a tragedy in the midst of this year to have a failure of, I would say, will to find the money to fund this bipartisan agreement you have made.

Incidentally, you can pick and choose from——you don't have to look to the Coburn-Lieberman proposal——although, frankly, we did this, too. We took a lot from the President's Fiscal Commission. And the President himself has recommended some changes in the last couple of budgets that would fund $50 billion. That is the part where he increases the premiums on wealthier beneficiaries.

Mr. PITTS. Thank you.

Dr. Rivlin, there has been a lot of discussion in recent years about the slowdown in the annual growth rate of Medicare spending. You have probably been following the literature and CBO's analysis pretty closely, but my question is pretty simple.

In your opinion, is the slowdown in Medicare spending a reason not to offset SGR reform? And based on your historical perspective,

do you think it is likely to rebound in coming years closer to historical averages?

Ms. RIVLIN. I don't think we should use the slowdown as an excuse not to pay for the SGR reform.

Whether this slowdown will continue, I think, depends in part on whether we make bolder moves to make the health system more efficient and more cost-effective. And the movement toward alternative payments, alternative payment mechanisms of various sorts——accountable care, medical homes, bundled payments——is an effort to do exactly that.

It seems to be working, and it may be part of the reason why the slowdown has occurred, but we can't be sure. And we do know there are going to be a lot more seniors in the future who are eligible for Medicare. And there are a lot more things that docs can do for us——really interesting and exciting things coming on line, and we are all going to want it.

So the upward pressure on healthcare spending generally and Medicare in particular is going to continue. And that is the reason I think that we should combine fixing the SGR with strong incentives to use alternative payment mechanisms.

Mr. PITTS. Thank you.

My time has expired. The chair recognizes the ranking member, Mr. Green, 5 minutes, for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Moon, some have suggested that the SGR and other reforms proposed should be paid for by shifting additional out-of-pocket costs on to Medicare beneficiaries. However, seniors already bear a significant out-of-pocket cost in Medicare now, and most are living on very modest incomes. For example, half of all Medicare beneficiaries have incomes below $23,500.

A Kaiser Family Foundation study found that an average Medicare household spent almost three times more out of pocket on health care as a percentage of income than the non-Medicare households, 14 percent versus 5 percent.

To me, this a clear illustration that we should not be shifting costs to seniors. Instead, we should be working to strengthen and expand the programs that provide an assistance to the moderate-income seniors.

Can you discuss the cost burden beneficiaries already bear on their relatively low income?

Ms. MOON. Thank you, Mr. Green.

Yes, I agree with you that the burdens are substantial. And particularly for those modest-income individuals that I mentioned, whose incomes are between 150 percent and, say, 250 or 300 percent of poverty in the United States, receive no protection of any sort beyond the basic Medicare program. They are the ones that are particularly vulnerable and for whom even fairly simple and small changes in cost-sharing can have devastating impacts, because they could cause people to not go and get care, which then ends up costing the system more, ultimately, when they become sicker.

I believe that the aspect that we need to think about in terms of this is that Medicare is not a really generous program. It is a less generous program than most of us who have employer-pro-

vided insurance or the standard programs that are offered through the ACA have, for example. So when you begin to raise premiums, raise cost-sharing, you are effectively cutting that back even further and making it a less and less generous program over time.

Mr. GREEN. Well, and I think most of us don't actually object to paying for it, it is just how you do it. Although I have to admit, last week we passed a bill on the floor that cost $54 billion that wasn't paid for that affected the Affordable Care Act. So if it is good for the goose, it is good for the gander——but paying for it out of Medicare and making seniors come up with more cost-sharing.

My next question: Aren't Medicare premiums already income-related? More specifically, can you talk about the existing income-related premiums and what income levels it affects and how these income levels compare to what is considered upper or higher income in other Federal policy, such as tax policy?

Ms. MOON. Yes. Medicare does have an income-related premium for both Part B and Part D now, and it starts at a level of $85,000 a year. So I rankle when I hear people talk about asking wealthy Medicare beneficiaries to pay higher premiums because, as a society, we like to talk about "middle income" stretching up to $250,000 a year of income but we are willing to talk about "wealthy" seniors at $85,000 a year.

The reason for that is it is very difficult to get high levels of revenues from income-related premiums because there simply aren't enough seniors with such high incomes or persons with disabilities with such high incomes that make it easy to get more money.

So when you begin to talk about further raising income-related premiums, you either have to make even lower-income individuals subject to such premiums or you have to raise those premiums to such a level that no longer is Medicare a good deal for high-income individuals. And that concerns me, as well.

Mr. GREEN. OK.

Dr. Moon, we have heard a great deal over the past few years about entitlement reforms. And these entitlement reforms, particularly in Social Security, are the safety net for our society——Medicaid and Medicare for the seniors and most vulnerable in our society——without considering the fiscal impact of tax entitlements, tax deductions, exclusions, credits, and other tax preferences which disproportionately benefit well-to-do Americans. And I think the President talked about that last night.

Can you talk about entitlements, both those providing essential services to seniors and low-income Americans and those providing tax breaks to more affluent Americans, and the relative role of each of these in the context of protecting the most vulnerable in our society and at the same time addressing our long-term debt?

Ms. MOON. A small question.

Mr. GREEN. In 15 seconds, by the way.

Ms. MOON. Fifteen seconds.

In addition to Medicare and Medicaid, Social Security is also considered an entitlement program. These programs all help support older people when they have retired. They enjoy enormous support. And they are also important in reducing some of the inequality that occurs as people go through their lifecycles and have bad

things happen to them. Medicare and Social Security provide that underpinning of support.

I believe they are really important programs. And if we are going to talk about changing programs like that, we ought to talk about revenue sources from other places if we are going to talk about making changes or looking for offsets.

Mr. GREEN. Thank you, Mr. Chairman, for your patience.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes, for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman.

And, Dr. Rivlin, I know you have been involved in a lot of different groups and think tanks in working on this issue. And a lot of times in Congress, we keep hearing, we need a lot more information, we need more information, we need more studies. I think Senator Lieberman said we just need some good courage and cooperation.

And so my question is, do you believe the information is there for us to move forward, or do we need another study, or is it time for bipartisan negotiations to begin and move forward?

Ms. RIVLIN. I am a studier, so I don't want to say you don't need another study, but I think you have enough information to move ahead now and, indeed, that you should.

And, in my testimony, I endorse the idea of actually accelerating the impact of the incentives to use alternative payment mechanisms that are built into the tri-committee bill. I think we know enough now to do that and to start them in, say, 2018 rather than 2023 and phase in over several years a movement to incent the medical profession to be in new kinds of organizations that take risk.

That is not going to be easy. We will learn along the way. But I think you can start now.

Mr. GUTHRIE. The trick is it is——the way you can measure, it is easier when somebody walks into an office, to know they walk in and pay for volume. It is hard to figure out how you pay for value, because it is hard——how do you determine in value. That is what is going to be interesting over the next few years to develop those models. So———

Ms. RIVLIN. Right.

Mr. GUTHRIE [continuing]. There will be more studies with that for sure, so we will keep you studying.

I know alternative payment models in the SGR. Is there specific things within Medicare currently today you think should be reformed in the current offsets to pay for it? Some suggestions in the current Medicare program?

Ms. RIVLIN. Yes, I think I do favor more means-testing of the premium. I think you can do that without hurting low-income people. I also think that the restructuring of the benefit package and the deductibles so you put together Parts A and B with a reasonable deductible, and then, in order to protect lower-income people but also not to discourage anybody from going to the doctor, you could have it not apply to physicians visits.

And there are other things that you could do. Accelerating the movement, the incentives for moving to stronger accountable care

organizations, for instance, would produce savings, we think, over time.

I am not in favor, unlike Senator Lieberman, of raising the age, partly because it just doesn't save very much money because if you are going to do it, you do have to put those people into some other plan like the Affordable Care Act.

Mr. GUTHRIE. Thank you very much.

And, Senator Lieberman, you had an op-ed in The Hill, and you said earlier today about a final bill, nobody is going to get everything that they want——I think that is what you said——but we can work together so we can tackle big problems. And in the President's fiscal year 2015 budget, he did include a proposal to charge wealthier seniors on Medicare more for Part B and Part D premiums. And it would save $50 billion——I think is what was in his budget——and roughly a third of the cost of the entire SGR bill. Do you think there could be bipartisan consensus for the President's proposal in 2015, for the 2015 budget?

Mr. LIEBERMAN. Well, that certainly should be the beginning of it. Bipartisanship always comes as a result of negotiation and compromise and understanding that you are putting a larger interest, which is a national interest, ahead of a more focused interest so you couldn't just sort of pass that one alone. But that takes care of——the President's proposal takes care of more than a third of the cost of the SGR replacement reform. And I think you would have to come up with some others that would appeal to people on both sides that could get you to the numbers you need to get it passed. But, no, I think that is a very strong beginning.

Mr. GUTHRIE. Thank you, Senator.

I just have 17 seconds. I just want to say remember if we do nothing with Medicare Part A, by 2030, the most optimistic assessment——and I was born in 1964. That is when every baby boomer will be retired. And if you look at other parts of the budget, about that time, that is when Medicare, Social Security, and Medicaid, and the national debt will be 100 percent of federal revenues. And even if you took the President's proposal in his campaign and went to the fiscal cliff and added, that is only another $40 billion. So unless you are going to go deeper into taxes and tax more people or you are going to reform these programs, they won't exist after 2030 unless we step forward.

Mr. LIEBERMAN. I agree. I agree with Dr. Rivlin. The facts are there, and the question is what you and we all as a country are going to do about them.

Mr. GUTHRIE. I yield back.

Mr. PITTS. The chair thanks the gentleman.

The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questioning.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I want to say that we do have a serious crisis in this country when it comes to budget. And, for me, it is the budget of the senior citizens. And right now we have a retirement crisis. People cannot afford to retire in the United States of America. And I say this at a time that our country has never been richer. This is the richest country on the face of the earth, and per capita GDP has never been higher, but as we all know, that is so unequally distributed

that ordinary Americans have not seen an increase in wages for the last three decades, and all of the growth has really gone to the top 1 percent. And now we have a situation where I think we all agree that the SGR has got to go. And, as I said, when the Democrats were in the majority, we did exactly that.

But this idea that we have to ask senior citizens, who are absolutely struggling right now, on this 50th anniversary of Medicare——one of the most successful programs we have ever seen, and undoubtedly this pay-for that we are talking about would put additional burdens on seniors: $85,000, as Dr. Moon pointed out, is now a rich senior. Some proposals have talked about lowering the income to $45,000, making people——seniors who make $45,000 considered rich enough to pay higher premiums.

I say shame on us as a country that we can't afford to provide health care to our seniors and persons with disabilities. There are plenty of places to look. We just passed——what did we call it——the Tax Increase Prevention Act; extenders, $45 billion unpaid for. As I said in my opening remarks, just earlier this month, the Republicans passed a bill to redefine "full time," and that cost $53 billion, unpaid for.

But now we are saying in order for doctors to get what they deserve and continue to serve seniors, we are going to ask senior citizens to pay more. I find that repugnant——I am sorry, and my hair is on fire——to say that we should go to the elderly and the disabled in our country. I agree that we have debt, but you know, projected Federal spending for Medicare and Medicaid have fallen by almost a billion dollars since 2010. If we compare the CBO's August 2010 and the August 2004 base lines, Medicare spending in 2015 will be about $1,200 lower per person than expected in 2010. So we are adding incredible savings because of the reforms in the Affordable Care Act, et cetera, to lower the cost of Medicare. And now we are going to turn around and say the seniors in this country are just having to spend more in order to save future generations from debt. I say we have plenty of money, and if we don't start talking about reasonable revenue, as the President did last night in his State of the Union, then, again, I say shame on us. And I hope the senior citizens and the people with disabilities are paying attention to this important debate.

I wanted to ask Dr. Moon, one of the things we expect to see in the budget that is proposed by the Republicans is, once again, this idea of a voucher program for Medicare. I wonder if you would comment on that and the kind of effect that that would have on Medicare beneficiaries.

Ms. MOON. My concern about a voucher program is that if we turn over to the private sector the responsibility for meeting the same kind of challenges that now have to face the traditional Medicare program, we won't necessarily have solved anything. The only way that you can, quote-unquote, solve the problem and make the budget burden for the Federal Government lower is if you insist that you are going to pay in terms of those vouchers less and less over time as compared to what Medicare would otherwise cost.

Then the question is whether or not private entities will do a better job at holding down the costs than Medicare does. I see no evidence of that over the last 40 years. And if that is the case, it will

simply be then the shifting of costs on beneficiaries so that instead of premiums going up at the slow rate they have been going up in the last few years, they would have to go up faster and faster, unless we really find a way of either magically empowering the private sector to do a better job than it ever has, or we find a way to assume that simply handing it over to the private sector causes people to use fewer services and fewer numbers of people to age into the program. I just don't see it as a solution per se. It is only a solution in a budgetary context if what you do is pay less.

Ms. SCHAKOWSKY. I referred to in my——well, we can call it a rant——the Affordable Care Act made some significant changes that actually has reduced the cost of Medicare. I wonder if you could talk a little bit about that and what we might expect going forward that will actually lower those costs even more.

Ms. MOON. I think we have not as yet seen the full impact of the reforms that the Affordable Care Act was hoping to put into place. I think we have seen some reductions in spending on Medicare that are attributable to that in part because of anticipating what the impact will be. Because as yet we are still experimenting.

We are still trying to figure out what these things will do, how well they will work, et cetera, but they are very promising at this point because, as Dr. Rivlin pointed out, they are really trying to emphasize quality and value rather than volume. That means coordination of care, which is a really essential part of improving health care in the United States of America. As a very recent primary caregiver for a very sick Medicare beneficiary, I can tell you coordination of care is very poor in the Medicare program now. A lot of efficiencies can be found if we make improvements in that area. That is what medical homes and ACOs have at their heart of what they are trying to do. We need to push for that, and I think it will pay off over the long run.

Ms. SCHAKOWSKY. Thank you. I yield back.

Mr. GUTHRIE [presiding]. Thank you. The lady yields.

Dr. Murphy, from Pennsylvania, is recognized.

Mr. MURPHY. Thank you.

Great to have you all here. This is very insightful.

First of all, I want to say with regard to some of the issues of persons paying more their first dollar as a way of trying to save money, I recall the Gallup poll that was done, I think, last November or December that said 38 percent of middle class people with a household income between $30,000 and $75,000 have delayed medical care because of costs.

So I ask this, Dr. Rivlin, if people delay care, does it lead to an increase in costs?

Ms. RIVLIN. Yes, and that is one of the reasons that I think you have to be very careful in how you do the cost sharing, and one of the proposals that we have looked at is to not have the deductible apply, as I said earlier, to physicians visits. I think that is a good idea. That means you aren't discouraging people, especially low-income people, from seeking physician care.

Mr. MURPHY. I have to keep moving. You support the Alternative Payment Model. I think that is an important point to acknowledge. I read here in the report from the Center for Healthcare Quality and Payment Reform, they say that the vast majority of healthcare

spending doesn't go to physicians. These scheduled payments represent only 16 percent of total spending in Medicare Parts A, B and D. Physician fee-scheduled payments over the next decade are expected to represent only 12 percent of total Medicare spending. However, physicians prescribe, control or influence most lab tests, images, drugs, hospital stays and other services that make up the other 88 percent. Does that sound correct?

Ms. RIVLIN. I didn't quite follow.

Mr. MURPHY. Well, basically that physicians' fees are a very small slice of that pie, but all the tests and everything else are the larger costs.

Ms. RIVLIN. Yes. And the hospitals are the big cost centers in health care.

Mr. MURPHY. And so the current system that is up there, I just want to get these points out to make sure we are looking into proper savings areas. Physicians lose revenue if they perform fewer procedures or lower-cost procedures, even if their patients are better off. Would you say that is correct in the current system?

Ms. RIVLIN. Well, that may be right, but as Dr. Moon was pointing out, there are a lot of things that could be better if physicians coordinated better.

Mr. MURPHY. I agree. I want to get to that. Well, that is what I mean. For example, one area of coordinated care, we don't even have integrated electronic medical records. Behavioral medicine and physical medicine are just completely disjointed. And as a cap on, for example, psychiatric days, we don't do that for heart disease or diabetes and say, I am sorry; you are only going to get so many pills, or you are only going to have so many visits for your kidney problems. But persons who have a chronic illness double their risk for depression, very high amongst seniors, very high. Untreated depression and chronic illness doubles healthcare costs, but we keep ignoring this.

So would you see an alternative payment model for you and Dr. Moon that really looked at pushing and rewarding medical care to coordinate their care to really improve health as a way to get savings out of this system far more than what we are trying to squeeze out in some of these SGR things?

Ms. RIVLIN. Yes, and I think you not only get savings; you get better medical care. You get better outcomes.

But it has to be said, the knowledge here is very much a work in progress. We are learning how to do that. Accountable care organizations seem promising, and I would suggest we strengthen them, but we don't know all the answers here.

Mr. MURPHY. Well, let me add one other thing here then. And that is that Medicare has a couple of times invoked some models that they said we want to do this as a pilot study, and sometimes a set of across-the-board changes that they have made with the DRGs or the RBRVS physician fee schedules, they have just done that. So should we also include here a mechanism whereby physicians could voluntarily go into an accountable payment system, so an alternative payment system, because not everybody will be ready for it, as an incentive to say, Let's move you toward this as a mechanism for reviewing this for the next year.

Dr. Moon, Dr. Rivlin, should we offer that?

Ms. MOON. I think something like that is potentially a good idea. One of the problems we still have, however, is that it is very spotty where these organizations exist and where there is the capability to do that. And when we think about rural or isolated areas, we also don't want to penalize physicians that are kind of trying to do it on their own and doing a very good job.

Mr. MURPHY. That is why I say voluntary so that some who are ready can do it. Some who are not will need a few more years. That will give them more time but not force it upon them.

Ms. MOON. But I just hope that it doesn't become something that is cost neutral and you say we are going to take it out of the hides of the folks who don't get involved because they may not be able to at this point.

Mr. MURPHY. I understand.

Dr. Rivlin, final comment?

Ms. RIVLIN. Yes. I think that is the spirit of what we are suggesting. Reward physicians who are willing to go into alternative payment mechanisms.

Mr. MURPHY. Thank you.

I yield back.

Mr. PITTS [presiding]. The chair thanks the gentleman.

I now recognize the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. I appreciate the opportunity.

To kind of follow up a little bit on Dr. Murphy's line of questioning with the Affordable Care Act, the incentives in there for incentive-based outcomes, for accountable care organizations, the coordinated care that I think is so important to really deliver the long-term health benefits, better quality care, as well as the big savings compared to all the other little things we are talking about and arguing about right now.

Could you talk a little bit about how the accountable care organizations and increased utilization of patient-centered medical homes, where the primary care physician gets involved, how that could actually help in generating a lot of savings for Medicare going forward?

Ms. MOON. I think that coordination, as I mentioned, is the real key here. One of the things, the low-hanging fruit, obviously, is making sure that you don't duplicate tests, that you don't duplicate things that don't need to be duplicated. When you don't have good recordkeeping and transportable electronic records, that is a problem. You want to improve in that area.

You also want to try to encourage and find ways to provide the right incentives for the care to be delivered in the right place at the right time. And one of the things that we still don't quite know how to do is think about making that happen. Consider the example of bundled payment, where you are putting together payments to hospitals and post-acute care providers, like skilled nursing facilities and home health. Who do you put in control of that bundled payment? It probably makes a big difference in terms of then where the care is delivered. If the hospital is in control, more is going to be done in the hospital and less in the skilled nursing facility and home health.

So there are a lot of things that still have to be worked out, and we have to figure ways to coordinate care.

The other thing that I would mention that I think is really important and a challenge is how to get consumers involved. One of my big pet peeves is when people talk about a patient-centered medical home, and they don't really involve the patient. They simply say we will do what is best for the patient. Patients need to be involved, not only to think about what care they need and don't need but also to cooperate and coordinate themselves to the extent to which they can. And we need to be realistic about it, but we need to get the patients involved.

Mr. SCHRADER. And that is where the primary care physician or healthcare practitioner or nurse practitioner can help make that actually happen.

Ms. MOON. Absolutely.

Mr. SCHRADER. Dr. Rivlin, with regard to some examples, you have talked again, just like Dr. Moon and Senator Lieberman, about good outcomes, value-based outcomes. The discussion has been, well, how did you measure that? Can you really measure value-based outcomes? I think the answer is obviously yes. Could you give us some examples of value-based outcomes that are, indeed, very measurable?

Ms. RIVLIN. One success so far has been not rewarding hospitals when the patient is readmitted in a very short period. That is measurable. Maybe sometimes it is unfair, but it has had a serious effect on a hospital's being much more careful not to discharge a patient who might come back really quickly. So that is one example.

Mr. SCHRADER. I will give you several others too. My state, we have gone to the, we call them coordinated care organizations, and we include rural areas. It is not impossible to do that in a rural area, quite frankly, especially in this day and age of telemedicine, where we have been able to actually drop the readmission rate in our hospitals anywhere from 10 to 20 percent. Stays for chronic obstructive pulmonary disease and heart issues, again dropping anywhere from 18 to 30 percent. Patient-centered medical home visits up 11 percent. I think it is important for the committee and subcommittee to understand there are ways to actually measure these things.

The last comment I would make, Mr. Chairman, is while I agree that Congress historically plays loose and fast with what the pay-fors are, whether or not we actually do pay-fors going forward, I think is extremely important that we do pay for this. The near-term situation is such that while our Medicare costs are, indeed, going down, I think it is part of the ACA. It is undoubtedly part of the ACA. It is also undoubtedly part of the economy. But we can't rely on that with the math problem we have in this country. We have a tsunami of folks my age and a bit younger becoming senior citizens, becoming eligible for Medicare. And that is not going to be cured under the current deficit reductions we are seeing. It would be unconscionable for us to avoid addressing this problem. We are so close. This committee and the other committees have come up with a very excellent solution for going forward on the SGR. We are this close to coming together on it. I think Sen-

ator Lieberman made a good point. All the points are out there that we need to figure out how to pay for this, $140 billion, $144 billion is probably the least costly fix to the SGR that we are going to see in our lifetime. And I would respectfully suggest that maybe the subcommittee, under the rubric of the committee, put together a task force to pick the least offensive ones.

We can protect the low-income folks. We came up with a definition in this committee of what we consider more low income. Certainly it is well below $250,000. I don't know if it is $85,000 or less, but we can figure that out. And I would really urge the committee to sit down and work together and figure this thing out because we are going to pay for it under this Congress. Time to get the job done.

I yield back. Thank you very much, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlemen and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

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

I appreciate it. Thanks for holding this very important hearing. I am constantly reminded about the importance that Medicare plays in the lives of my constituents when I am back in my district in Florida in the Tampa Bay area. In 2012, there were about 145,000 Medicare-eligible beneficiaries in my district. Medicare is an important program. I want to make sure whatever we do in Washington, that we protect current beneficiaries and future beneficiaries. We need to make sure that Medicare is on strong financial footing to be there for our parents, for us, and for our children.

Senator Lieberman and Dr. Rivlin, in your Medicare modernization proposal, you talked about providing a unified deductible access across Part A and B. Can you talk about how this would provide clarity to seniors when understanding their Medicare benefit and discuss how this would reduce overutilization.

Mr. LIEBERMAN. Thanks, Congressman.

Very briefly, it is actually very hard to describe the current system of deductibles under Medicare. It is so confusing. So I think the first benefit of combining Part A and Part B into a single deductible——Senator Coburn and I recommended $550 annually—— is the clarity. And incidentally, in most private insurance plans, there is a clarity in deductibles. There is no reason why we shouldn't give the Medicare beneficiaries the same clarity. The second hope, obviously, is that as you create that clarity, you will create in the beneficiary kind of a second thought about overutilizing services. You don't ever want anybody to not go to the doctor or the hospital or get a prescription drug because they are worried about the cost, talking about hospitals and doctors in this combined deductible.

But there is clearly overuse. One of the more controversial recommendations that we made, but it has been included in some of the other studies done, is to limit the availability of the Medigap coverage because, for instance, not to have it pay for all of the deductible and have it pay for a limited amount of the out-of-pocket because there is study after study that show that people who have Medigap use 25 percent more Medicare services than people who don't without any discernible increase in healthcare results. So, look, if we are going to solve this problem, everybody is going to

have to help do it, including the beneficiaries, and this is a way to try to incentivize them——not to stop going to the doctor or the hospital——but to make sure they need to before they do.

Mr. BILIRAKIS. Thank you.

Dr. Rivlin?

Ms. RIVLIN. Yes, I agree with that and especially would like to emphasize the part of that about Medigap. The effect of Medigap very often is to make health care free, and when it is free, you tend to overuse it. So putting some limits on that I think is important.

One other proposal that often goes with restructuring the deductibles is to put a limit on the out-of-pocket costs, which we don't now have. That goes in the other direction. It would cost something, but it would be a big benefit to especially low-income seniors who run up against high out-of-pocket costs.

Mr. LIEBERMAN. That was one of the gives and takes——excuse me, Mr. Chairman——that Tom Coburn and I were involved in. So we did what we just did about the deductible and Medigap, but Tom agreed that we should put a limit on how much out of pocket a Medicare beneficiary would have to pay, and that will have a significant——real but also psychological——effect on our seniors.

Mr. BILIRAKIS. Interesting.

I have one more question, Mr. Chairman.

Dr. Rivlin, in your testimony, you mentioned one idea was rewarding beneficiaries for using generic drugs. Can you elaborate on how to incentivize beneficiaries to choose lower-cost options?

Ms. RIVLIN. Yes. I think it is——often the beneficiary doesn't care whether the doctor prescribes the generic or the brand name. It doesn't matter to them. It should matter. They should pay a little less if the generic is prescribed.

Mr. BILIRAKIS. Thank you.

I yield back, Mr. Chairman. I appreciate it. Thank you.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you to Chairman Pitts and to Ranking Member Green for holding this important hearing.

I have long been a supporter of fixing the SGR. It harms providers and consumers alike, the SGR. It keeps us from true innovation in the healthcare sector, but the conversation often stops right at the crisis point, how to make it to the next paycheck, and rarely moves to one where we can really discuss our vision for our healthcare system in the future and how to get there. Last year we finally got everyone on the same page, both in the provider community and here in Congress, but despite the massive effort undertaken by many of us here on this subcommittee in the last Congress to come up with a solid plan to end SGR and once and for all set Medicare on a path toward improved quality and stability, we never made it to the last mile. In the end, it was political disagreements, not policy concerns, that kept us from the finish line. And I don't believe we can afford to do that again.

Mr. Chairman, I am a longtime member of this Health Subcommittee and a healthcare professional myself. And a permanent solution to the SGR problem must be our top priority, so I urge you to ensure that this hearing is but the beginning of swift action to-

ward passage of a bipartisan, bicameral compromise legislation, agreed to last year by March 31, not just a box being checked before moving on to other matters. Anything less would be so unfair to Medicare patients, to the provider community, and to all who put their differences aside, which we did last year to find a strong policy compromise.

I would like to also take a moment to remind the chairman and my colleagues that while SGR, the replacement policy for SGR, should not be reopened, we shouldn't forget the additional policies that need to be included with this bill. Commonly known as extenders, these programs, like lifting the Medicare outpatient therapy session cap and extending the qualifying individual programs that help low-income seniors afford their Medicare premiums, these are all critical to ensuring the strength of the Medicare system and must not be forgotten.

And I have a concern that some of the conversations here today represent a step backward in finding a permanent solution, and I think we need to be clear. Reform the SGR on the backs of seniors and persons with disabilities who receive care is one of those damaging conversations.

Now I have a question for you, Dr. Moon. We have heard a number of proposals that would reduce the Medicare benefit for those currently on the program or even eligible for Medicare. For example, Mr. Lieberman mentioned in his testimony that his proposal would gradually raise the Medicare eligibility age from 65 to 67. We have heard this proposal from leaders on the other side of the aisle as well.

And I want to be clear about my view: This is a bad policy. It is shortsighted, and its consequences are so far reaching. It would break our Nation's longstanding promise to its people that if you work hard and pay into the system, it will be there for you when you turn 65. It would raise healthcare costs for these individuals at a time when they are most often in need of saving.

In fact, the Kaiser Family Foundation estimates that two-thirds of 65- and 66-year-olds——and that is 3.3 million people——would have to pay on average $2,200 more dollars for coverage than they would if they were on Medicare. So I would like to ask you, Dr. Moon, to speak to the policy effects of raising the Medicare eligibility age.

Ms. MOON. Congresswoman, I agree with you that raising the age of eligibility has a lot of problems, particularly for the modest-income individuals who would find it difficult to afford that. Higher-income individuals now actually are pretty well taken care of by this because we have a Medicare secondary payer program in which if you have insurance through your employer and you are still employed, Medicare is secondary, and it is not very costly at all.

Moreover, you would keep eligible those who are disabled in the program who are 65 and 66, and they are the expensive folks, so you wouldn't save very much money, but you would put at considerable risk folks who wouldn't qualify for disability, wouldn't qualify for low-income protections, and would have to pay these substantially higher premiums to get their insurance somewhere else.

Mrs. CAPPS. Thank you. You know, I have a Kaiser Family Foundation chart here that I would like to submit for the record that shows that Medicare beneficiaries aged 70 and over account for 63 percent of Medicare spending, with persons with disabilities accounting for another 22 percent. Aren't most of the costs in Medicare programs generated by those older than 67?

Ms. MOON. Yes, they are, and when you take the 65- and 66-year olds out of the program, the other thing that will happen is the premiums will go up in Medicare for everyone else because you are taking inexpensive people out of the program and leaving only the more expensive people in the program, another unintended consequence.

Mr. PITTS. Without objection. We will enter that into the record.

[The information appears at the conclusion of the hearing.]

Mrs. CAPPS. Thank you very much.

Mr. PITTS. The gentlelady yields back.

The chair recognizes the gentleman from Indiana, Dr. Bucshon.

Mr. BUCSHON. Mr. Chairman, I was a practicing cardiovascular and thoracic surgeon for 15 years prior to coming to Congress, so, first of all, I would like to say I am grateful to be on the committee and on the subcommittee and discuss this very important topic.

Briefly, I am going to comment on another thing that we are not really talking about today but to help the Medicare program is to really get overall healthcare costs, bending the cost curve; price transparency; quality transparency; work towards a more market-driven economy in health care versus a price-fixed economy; of course, tort reform to decrease the cost of defensive medicine, among many others. Coordination of care is very important, including coordinating medical records, electronic medical records, to be able to communicate with each other. This is a significant problem even within my own community.

With that, Dr. Rivlin, in Senator Lieberman's testimony, he states that if we do nothing, Medicare Hospital Insurance Trust Fund will become insolvent at some point in the next decade. That means it will have exhausted its reserves, and it will pay out more in claims than it receives in taxes. As a former CBO Director, how real do you take this threat if Congress fails to act to improve the financing of the Medicare program?

Ms. RIVLIN. Oh, it is very real. Now, there isn't an exact drop-dead date. We change that estimate every year, depending on how rapidly costs are going up, but it is clear that on almost any trajectory you can imagine, that we will not have enough revenues coming in to support the current program for beneficiaries. Now, that doesn't tell you what to do about it, but it is a real problem.

Mr. BUCSHON. And what might be the result of that to seniors? Say that did happen, the next day, what would happen? What would be necessary with the program if we didn't change it and it got to that point?

Ms. RIVLIN. Well, you are assuming that Congress doesn't do anything. The Congress would do something, but it would be more expensive to wait than to gradually phase in the kinds of reforms that we have been talking about today, which we all hope will make the health system more efficient and give the beneficiaries of Medicare better care for less money or less rapidly increasing costs.

Mr. BUCSHON. The Congressional Research Service in a memo dated April 16, 2012, opined on what would happen should Congress fail to address the coming bankruptcy or insolvency date of the Medicare Hospital Insurance Trust Fund, and I quote, There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur. For example, there is no authority in the law for the program to use general revenue to fund hospital services in the event of a shortfall. Plainly put, Medicare is not authorized to pick which claims to pay and which not to pay in the event the program no longer has funds to cover overall costs.

Senator Lieberman, on that point, which I think is very important, if we do nothing, the Medicare Hospital Insurance Trust Fund will become insolvent. The Congressional Research Service says that there is no authority for Medicare to pay hospital claims in the event the program does go insolvent. I think you will probably agree with Dr. Rivlin that the problem is real, but how might this impact if there isn't action, how might this impact access to health care for senior citizens?

Mr. LIEBERMAN. Thanks, Doctor.

The problem obviously is real statistically, as Dr. Rivlin said, under almost any imaginable set of scenarios. This prospect, Dr. Rivlin is probably right, in an atmosphere as we got up to midnight and it looked like the Hospital Insurance Trust Fund was going bankrupt, Congress would probably come in and fix it. But you just think about the instability that would cause in our healthcare system and the high anxiety it will cause among seniors. So this is a question of whether, like so many, whether Congress and the Executive work together to solve a problem before it becomes a crisis or a catastrophe, because, inevitably, that is what is going to happen. The people that have spoken today I respect. Obviously, to fix this you have got to ask people to do things they don't want to do.

Dr. Coburn and I, I think, came up with a proposal that was ultimately pretty progressive and tried to share the responsibility for avoiding the catastrophe that you described. If that catastrophe was not on the horizon, of course, none of would do any of this. We would just keep going along, but that is putting our heads in the sand, and that is not what I know any of you came here to do.

Mr. BUCSHON. I think we can make the case for incremental reform, and the SGR proposal may be a great opportunity.

I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes of questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I have been going back and forth between the other subcommittee; so I apologize for that. But I do want to state for the record that even though I have a "D" next to my name, I do not associate myself with the comments of two witnesses here today. While I respect their prerogative to be here, I don't believe that we need to cut Medicare any further, especially on the backs of seniors. Robbing Peter to pay Paul is how I coin it, and I am deeply opposed to many proposals discussed here today. If we insist that we have to pay for the SGR fix bill, revenues and other offsets outside health programs should be on the table. And, unfortunately,

all too often around here, our health dollars are used to pay for nonrelated bills, tax bills in fact, and the reverse should be the case.

So, Dr. Moon, if I could ask a question, my Republican colleagues have proposed keeping tax levels at about 18 percent of GDP, which is in line with the average level 60 years ago. What we have known about the aging of poor populations and the increasing need for healthcare coverage under Medicare, which I might point out is a demographic problem, not a cost control problem, is it realistic to keep revenues at that level? That is my first question.

Ms. MOON. I don't believe that it is realistic to keep revenues at that level if your goal is to have a healthy and viable Social Security, Medicare, and Medicaid program that serves this population.

Interestingly, if you look at polling of citizens, they all say they are willing to pay additional taxes to make sure that these programs remain healthy. We also know that when Medicare was passed in 1965, people talked explicitly about the fact that there was going to be an aging of the population. The worker-to-retiree ratio was going to change. This was all known, and what was said at that point in time is that revenue increases would be necessary. Payroll tax rates would have to go up. Because they did not want to have them be so high in the beginning to be a drag on the economy, they thought this was better to be done in gradual increments over time.

I believe that revenues need to be thought of as part of the package. I believe, even though I am a very strong supporter of beneficiaries and protecting the beneficiaries, that as a society, we think about what is the fairest way to ask people to pay for programs that we value as a society. And if that is partially from beneficiaries and partially from revenues, I am fine with that, but I think taking one side off the table and saying we are not even going to discuss it is very poor policy and not what the American public really wants to see happen.

Mr. PALLONE. Well, thank you.

Let me ask you another question. In Congress we have been passing these so-called doc fixes to the SGR for more than 10 years. We have been patching the SGR for so long that the Congressional Budget Office doesn't even take seriously the possibility we won't. Is it fair to say that the SGR has become a budget gimmick? Isn't it more fiscally responsible to pass the repeal-replace legislation without paying for it than to not pass it at all?

Ms. MOON. Well, in many ways, that becomes a political issue. When I look at what Part B is all about, it says that you are supposed to pay for Part B out of general revenues and premium increases from beneficiaries as the costs go up over time. That will happen naturally if you change the SGR. There is nothing in the law——people want to talk about the law and the trust funds and so forth——that require you to pay for it.

If as a Congress the Congress decides it wants to pay for things going forward, I don't have a problem with that. My problem is then to say that it can only come out of beneficiaries as a solution I think is way too narrow a reading of what is good public policy.

Mr. PALLONE. Let me try to get this last one in. My Republican colleagues insist that we pay for the SGR repeal. However, they

had no problem voting to increase the deficit when it was politically convenient. For example, last week they passed another ACA, you know, the 30-to-40-hour rule that would cost $53 billion. And they didn't pay for that. And more than 50 times, they repealed the Affordable Care Act. And that would have cost the country more than $100 billion each time. So these doc fix patches have cost the American people $169.5 billion more than the $144 billion cost of the bipartisan, bicameral repeal. If we don't do our job and pass the SGR repeal, how much more money will be wasted that could have been used for the permanent fix?

Ms. MOON. Kicking the can down the road, as people have said, and having only temporary fixes is a really poor way to do policy. It is the absolute worst of all possible options, I believe. On the other hand, you also don't want to see the SGR go into effect and slash payments to physicians and have people defect from the Medicare program. A question, I think, that you raise is a very legitimate one in terms of what is most important and how to achieve change. Just as I am opposed to having beneficiaries pay, I also think good policy means you do need to look at what you are going to do instead of this because we do make these decisions that affect health care going forward, but I think that there are a lot of solutions that one could look at and a lot of changes that need to be looked at, not as a way to pay for another fix but as policy unto themselves. If we think that raising taxes, there is a good reason to do it for some purpose, if we think that cutting benefits has a good purpose, those should be done on their own merits and not just because you are using them as an excuse to get another desirable policy change.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from Indiana, Ms. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman.

I happen to be one of the members of this subcommittee that does believe we need to explore ways to pay for this, and I would like to start out with Dr. Rivlin, because based on the breadth of your experience and your time working as an honest, data-driven policy expert and studying bipartisan manners of doing things, what would you say is the best chance and the best package that we could put together in a bipartisan way to pay for the offset of the SGR? If you could be queen for the day and pick——and I know you have mentioned a few things already——but if you could put together the package that you would like to see us start with, what would be in that package, Dr. Rivlin?

Ms. RIVLIN. Well, there would be quite a few items, and I would put in the increasing premiums at the high end. I would put in accelerating the transition to——accelerating the incentives to payment reform that I think is good in itself and would generate the savings. And I would put in rewarding the use of generic drugs more. I would put in more competition, competitive bidding, starting with lab tests, but you can use competitive bidding in quite a lot of things that Medicare providers buy. But I would put the biggest emphasis, I think, on the transition to alternative payment

models because that is not on the backs of beneficiaries. Beneficiaries will benefit if they have better coordinated care and care that is directed toward outcomes rather than just more services.

Mrs. BROOKS. And I am glad that you emphasized that at the end because the proposals that you put forward would not be to the detriment of beneficiaries in your studies. Is that correct?

Ms. RIVLIN. Yes. Except for the increase in premiums, I don't think the things that we are suggesting are on the backs of beneficiaries, as you have said.

Mrs. BROOKS. And, Senator Lieberman, knowing the congressional calendar the way that you do and based on your experience, and you have more experience——I am just starting my second term——negotiations on something as complex as this, binding the office offsets we believe necessary to pay for SGR——most of us believe——how important is it that we begin to work now on this, and what advice would you have for this subcommittee and how we should accomplish this task?

Mr. LIEBERMAN. Thanks very much for the question. I mean, obviously, the sooner the better because the session moves on, but also you are facing the SGR deadline, which will be another crisis, and you will be into another time when people will be attaching all sorts of things to it and holding up action. And meantime doctors and beneficiaries will be very anxious about what is going to happen, so I would say the sooner the better.

The second is to acknowledge as you begin to negotiate that you have achieved something quite significant and a bit unusual in the current mood in Congress, which is you have agreed on an SGR replacement and reform. I would say that to finance it, I personally have said that I think you have to offset it, and, frankly, beyond the philosophy or ideology of it, I don't think it is going to pass if you don't offset it so you have got to deal with that reality. And then it is a question of finding a balance of ways to do so.

Incidentally, the proposal I have talked about, it doesn't only, it doesn't even primarily build on asking beneficiaries to do more. It asks people based on their income to do a lot more. I think one thing that is missed here, Mr. Chairman, Mr. Green, is that in the current situation, most people don't realize——but I know the Members do——that most of Part B, doctors' insurance, 75 percent is not funded by payroll taxes; it is funded by general revenue. And more than 80 percent of Part D, prescription drug, also funded by general revenue, tax revenue. That is fairly progressive, but it also hits a lot of middle-income people. Therefore, it is not as if, if you don't do something here to ask a little more of beneficiaries and more of people of higher income, that the money is just going to come down from heaven. The general taxpayers are going to be paying more than their fair share.

Look, you have been all through this. When the system works, people put the national interest ahead of everything else, and their constituents interest even though it is not short term, which this program is going to go belly up unless there is a compromise agreement to save it.

Mrs. BROOKS. Thank you. Thank you for continuing to care and to share with us your advice.

Thank you. I yield back.

Mr. LIEBERMAN. Thank you.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for questions.

Mr. KENNEDY. Thank you, Mr. Chairman.

Thank you, Ranking Member.

And, once again, thanks to the witnesses for your testimony. Thank you for your service and all the work that you have dedicated to these important issues. Thank you for sticking around so long this morning.

It is a nice thing to do when you get all the way down to this end. So I appreciate it.

Dr. Moon, there have been a number of comments today and we have heard from a number of folks, both elected officials and policymakers, that have suggested that the financial Outlook for Medicare is bleak, that it is potentially near bankruptcy, indicating that without urgent action, the program won't be financially solvent in the near future. That has been at times used to justify some pretty significant cuts to the program. Can you help us understand the financial health of Medicare and what fiscal challenges and what kind of time frame we are looking at in terms of ability for current Medicare revenues and the Medicare Hospital Insurance Trust Fund to continue to cover the cost of the program?

Ms. MOON. The Medicare program and the Social Security program are both very different than other parts of the Federal budget because we look 75 years ahead and try to figure out what is happening in these programs. Technically speaking, the spending on defense faces insolvency at the end of this fiscal year because you have to fund it. That is not the case for Medicare and Social Security, and in many ways, I believe the trust funds were established to try to be an early warning device and not as a bludgeon to say, you are going to have to cut the program, but rather to say, what does it look like it will take to continue forward with the program?

Then it is totally legitimate to ask when that outlook becomes bleaker, what should we do? Should we raise taxes? Should we cut benefits? Should we find others ways to change the program to improve it. I don't think anyone here would disagree that if you could find ways to make Medicare more efficient and more effective, we should do that in a heartbeat. The question is when you have done that as much as you can, then who do you hold accountable? Do you say, beneficiaries, you are the ones on the hook for this, or, as taxpayers, we are also on the hook for this, and I believe it has to be a shared responsibility. I believe, therefore, that it is convenient sometimes to talk about the trust fund as forcing us into action, and that can be used very effectively. It can also be used to justify poor policy as well in an emerging situation.

It is also the case that the trust fund balance looks better and worse. I was a public trustee from 1995 to 2000, and my husband always likes to say I saved the program, that it went from 4 years before bankruptcy to 37 years. And it had almost nothing to do with me. It had to do with policy changes that were made, most of them in terms of improving the program over time and not penalizing beneficiaries.

Mr. KENNEDY. Just kind of bouncing off that for a second, Doctor, and some comments by the ranking member of the committee, Mr. Pallone, and actually Mr. Schrader as well, both of whom, and I am sure others have as well, mentioned the impact of the Affordable Care Act on the solvency. Could you discuss that a bit? And I understand that the trust fund is now in good standing for an additional 4 years out to 2030, given current estimates. But given the fact that there have been some savings realized, particularly over the past several years, forecasting that forward, what do you anticipate?

Ms. MOON. Forecasting forward is always very difficult because there are a lot of things that can happen. No one expected Medicare to slow down as much as it did, although it was kind of a happy combination of several things——or an unhappy combination, I might say, in terms of the poor health of the economy certainly contributed as well as these reforms that we think are important.

I believe we are on the cusp of making major changes in health care because we have to. Health care is expensive for everyone, not just for the Medicare program, but for all of us who use healthcare services. We need to get those costs under control. And I believe that we are now serious as a country about doing that. The ACA put in place a lot of reforms, not all of them aimed just at Medicare but aimed at changing the healthcare system overall that show promise and are supposed to be evidence-based in moving forward. There are going to be fits and starts. Some of them are going to work well. Some of them are not. We are not going to be able to put anything on automatic pilot. We are going to have to keep working at it.

But I am reasonably optimistic that we are going to find ways to keep the costs of health care within bounds over time and that the health of the trust fund will look pretty good even if we don't do a lot of other things except work on these reforms over time.

Mr. KENNEDY. Thank you, Doctor.

My time is up. I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Texas, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Again, thanks for doing this hearing so early in the new term.

Senator Lieberman and Dr. Rivlin, let me just ask you a question because I wasn't here when Medicare started. I am not implying that either of you were.

Mr. LIEBERMAN. I want to be clear that I wasn't either.

Mr. BURGESS. But my study of the situation, the Medicare Part B premium was originally 50 percent and was later reduced by Congress to 25 percent. Is that not correct?

Mr. LIEBERMAN. That is correct.

Mr. BURGESS. There has already been a major adjustment as to where those moneys actually come from. I do want to add just that it has been brought up by several other Members, but I think it is important that we pass this. It was important last year. I regret very much that the Senate did not attach as much importance to it as the House did. I think there was a real opportunity that was

missed last year, but it is up to us to make our own opportunity this year. We do have to get to 218 votes in the House. Last March, we got a vote on the repeal of the sustainable growth rate, the essential policy that I already referenced, and it attracted every Republican vote and two dozen Democrats. It was a significant vote. That path to 218, I believe includes a path that is offset. And the overseas contingency operation money, maybe, maybe not, but I think those contingencies overseas are actually happening even this morning so that money may, in fact, no longer be there.

Senator Lieberman and Dr. Rivlin, you have both been there; Dr. Rivlin, in the administration, and Senator Lieberman in the Senate. You have been there when big deals were done, when hard things were done, hard legislation was passed, and people had to come to agreements and compromises. Do you think that with what you know of where we have been already with this, isn't it now time to get that deal done and to get those compromises done? Can you foresee a path forward where this one can actually move?

Ms. RIVLIN. I can. I am also an optimist about these things, but there are many examples, welfare reform, for example, wasn't anything that either side exactly loved, but it did get done. And I think you are at that moment when you could have the advantages of fixing the SGR and also putting the whole health system on a better track.

Using the overseas contingency fund seems to me to forego the opportunity that you have to pay for the SGR repeal with pay-fors that are actually good health policy. That is what you ought to be looking for, and I think there are quite a large number of them.

Mr. LIEBERMAN. Thanks, Congressman.

It seems to me that, again, I repeat, you have taken a big first step in the agreement on SGR replacement. Now, in a way, you are at the hard part, which is, how do you pay for it? But if you have got the will, you can do that. There are all sorts of ways to pay for it reasonably.

Now, the reason I am proposing that, if I may cite again the philosopher of Chicago, Mr. Emanuel, "A crisis is a terrible thing to waste." You have got a crisis here———

Mr. BURGESS. That actually didn't work out for us so well.

Mr. LIEBERMAN. Yes. No. I remember that. I was hoping your memory was short, but the reality is that——let me cite these numbers that really struck me when I was working with Senator Coburn. So our proposal was estimated by the various authoritative groups to save between $500 billion and $600 billion over 10 years, but here was the stunner: $10 trillion reduction in the 75-year projection of unfunded liabilities of Medicare.

So if you use this SGR crisis, if I can refer to it that way, and then fund your answer to the problem, your solution to the problem, with some Medicare reforms you can agree on, then you are going to have an——you are not only going to solve that problem, you are going to have an enormous long-term effect on the viability of the Medicare fund.

And, look, the public is——it is sort of unconventional politics. Maybe I see this more from outside than I did inside. I think the public really wants Members to do things that aren't conventionally political, and say no to some groups but say yes to the future

of Medicare, to the future of the country, in the sense that it is not going to be burdened by unbelievable debt.

Mr. BURGESS. Dr. Rivlin, I just want to point out that along the lines of being an optimist, I have introduced an SGR repeal every term in Congress since 2003, even———

Ms. RIVLIN. Good.

Mr. BURGESS. So we only had to push one stone up one hill.

Ms. RIVLIN. Someday it will happen. Maybe this day.

Mr. LIEBERMAN. You deserve a medal.

Mr. PITTS. The gentleman yields back.

The chair recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman.

And, Mr. Chairman, and, to Ranking Member Green, thank you very much for making this one of our first hearings of the new session.

There is nothing more nonsensical than the SGR patch from year to year by the Congress. It is absurd. And we need to act now to permanently repeal it. And time is of the essence, because the current patch runs out at the end of March. And I am heartened, because we did have a bipartisan bill last term. We came very close. And we need to work together to get that bill on the floor and fix this once and for all.

That bill is important, because it repeals the SGR and it establishes a new framework for reform, what Dr. Rivlin has said, more efficiencies, and Dr. Moon says, a greater coordination of care. It simply now begins to transition Medicare from a volume-based system to one on value, coordinating care, the new medical homes. We are smarter now. We have learned the lessons of the past, and we need to put them to work.

I would encourage my Republican colleagues, as they move towards the budget season, that they dispense with the very simplistic balance sheet policy that says Medicare should be a voucher system or premium support, because it simply shifts the cost to the beneficiaries; it does not solve the overarching issues of what we have learned over time. And it is an important——in reform, the much more difficult piece is going to be reform. And it is not one size fits all. It is pharmaceutical costs. It is working to weed out fraud and abuse. It is a lot of the ideas that have been floated today, but one idea that was floated that I think we need to set the record straight on right now is that asking beneficiaries to put more skin in the game, whether it is the Medigap or others, is going to save us money, because I know a lot of economists believe beneficiaries need to have more skin in the game, but the National Association of Insurance Commissioners reviewed the literature just recently and put together an expert analysis. They were unable to find any evidence that cost sharing encouraged appropriate use of healthcare services. In fact, they found that cost sharing would result in delayed treatments that could increase cost and result in adverse health outcomes.

Dr. Moon, are you aware of this analysis? And do you agree———

Ms. MOON. I am aware of this analysis and analyses that go back many, many years to where what you find in many cases is the

way that cost sharing works is it pushes costs onto someone else. And if they can't afford to pay, then they don't get the care.

It very seldom discourages use of unnecessary services. It, like the SGR, is a really broad-based penalty, where you are trying to discourage behavior that is a much more subtle behavior. You don't want people not to go to doctors. You want people not to get unnecessary care. And to have an across-the-board requirement that people pay X percent or put certain amount of skin in the game just doesn't get you there.

And, in particular, remember that most healthcare spending is for people once they are well in the grips of the healthcare system, and they are not asking any questions about use of services. Those are the very sick. Those of us who are healthy account for such a trivial part, that having us be a little bit savvier consumers just doesn't really work out.

Cost sharing just is a pretty unsubtle mechanism to use. There may be times when you use it, and we certainly use it because we are asking people to share in the costs of healthcare, but let's not assume that it is this subtle mechanism. It is simply saying, we are going to ask you to pay more instead of us.

Ms. CASTOR. Thank you very much.

And I would like to ask unanimous consent, Mr. Chairman, to submit into the record the analysis and letter from the National Association of Insurance Commissioners on the topic. And America's Essential Hospitals also have submitted a letter for the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. CASTOR. And I will just make one final point before I close, and that is to really encourage my colleagues on the Republican side. We were so close last year, and the SGR repeal was combined at one point with one of the——how many, 50——in the series of repeal of the ACA, wholesale repeals. This is too serious to do that again. We are ready——we are so close. And the longer we put it off, the more expensive it will be, so I will encourage us to get to work and really shoot for resolution by the March 31st deadline.

Thank you, and I yield back.

Mr. PITTS. The chair thanks the lady, and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

And I also want to thank you for staying a longer period of time. I am a fairly senior Member, but I didn't get here on time, so I got pushed down to the bottom.

In fact, Senator Lieberman, I was here in 1997 when we attempted to balance the budget, and the SGR arrived.

Mr. LIEBERMAN. Right.

Mr. SHIMKUS. And we have been fighting the battle ever since, so I am part of the problem of where we are at today.

Mr. LIEBERMAN. Both of us are.

Mr. SHIMKUS. And so I thought——Tom Coburn served in this committee when he was a House Member, and we know him well.

And, Dr. Rivlin, I was one of the 16 Republicans who supported the Simpson-Bowles———

Ms. RIVLIN. Good.

Mr. SHIMKUS [continuing]. Vote that we had on the floor. There was only 38 Democrats who supported that, and 54. Just shows you the challenges we have.

Mr. LIEBERMAN. Right.

Mr. SHIMKUS. I always put a chart up on the screen. It is a budget chart; I think it is 2013. And it just highlights what you all know and the message that we have got to continue. I think former chairman of the Joint Chiefs of Staff said the debt is a threat. Now we are at $18 trillion. So when we have these government shutdowns and battles, it is only on the blue portion. The red is running uncontrolled. It is an entitlement system, mandatory spending; it is things that we don't get control over.

So I just think it is wonderful that you are here, because the proposal is, if I understand, listening to a lot of great questions, is that we have an opportunity to use the SGR debate and tweak the mandatory spending, or the entitlement side, which has to be done. We just can't no longer continue to go down this path. And I do think there are people willing to, but I was talking to Dr. Burgess, and I asked him, do you really think we could tie these two together? And you hear some of my colleagues, no, don't touch it. Let's fix SGR. We will live to fight on the mandatory spending another day.

So insurance companies would do actuary tables. They would look at the amount of money they would have available to meet their obligations. So the question is tweaking that. And the benefits are really long term.

I think, Senator Lieberman, on your opening testimony you said——well, you mentioned $10 trillion down.

Mr. LIEBERMAN. Yes.

Mr. SHIMKUS. That is not chump change. That is real money here in Washington these days. So one of the simple questions is——and again, and, Senator Lieberman, in your testimony, you mentioned the Social Security Administration. There are a lot of seniors whose annual income is over $1 million, so can't we ask them to pay a little bit more into the Medicare beneficiary that they are receiving if they are taking that? I don't think that is out of line. In fact, these entitlement programs are for the most needed. There is always this debate. Well, they paid in it, they are entitled to it, so they get it, regardless of how many have been blessed by this country and the largesse of their ability to accrue wealth, and I think we better have it for the poor.

Senator Lieberman?

Mr. LIEBERMAN. Look, we should ask the wealthy to pay more. And in the proposal that Senator Coburn and I put forward, we did ask the wealthy to pay more. Frankly, it is still——Medicare is still a better deal than they could generally get in the private sector.

And, again, I would say that because Part D and Part B are mostly paid for by general tax revenue, and I will——a disproportionate share of the general tax revenue comes from the wealthy. They are paying for a lot of the program. But I do want to come back to what I said: It is not as if the current system is fair to everybody. The middle class is also paying a lot of taxes, and those taxes are paying for most of Part B doctors and Part D prescription drugs.

So sure, I mean, it is consistent with our whole system. We should arrange to fix this in the fairest and, dare I use the word, most progressive way we can.

Mr. SHIMKUS. And, Dr. Rivlin, you talked about how raising taxes might be counterproductive in your testimony. Did I read that correctly?

Ms. RIVLIN. I don't remember saying that, but I am in favor of more revenues, actually, in general, but in a balanced way, in the way that we did in Simpson-Bowles and the Domenici-Rivlin plan, which involves major tax reform, getting rid of many of the loopholes that benefit upper-income people. If you do that right, you can actually lower the rates.

Mr. SHIMKUS. Right. Right. Well, again, these are debates that I have been yearning for, for my now 19th year of being here in Washington. We just can't hide underneath the rock. And I am glad you have come, and I look forward to working with you. Thank you very much.

Mr. LIEBERMAN. Thanks, Mr. Shimkus. Seize the moment.

Mr. PITTS. The chair thanks the gentleman, and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questioning.

Mr. ENGEL. Thank you very much, Mr. Chairman, and thank you for holding this hearing.

And congratulations to Mr. Green for being in his position. And I want to thank all the panelists for really good testimony.

My good, dear friend Joe Lieberman and Dr. Rivlin, Dr. Moon, thank you so much.

What strikes me——because the questions I had to ask have long since been asked and answered——what strikes me in listening to the panel is you are all saying different things, but you are also really saying the same things. And I really agree with much of what each of you has really said.

Dr. Rivlin, you just finished the last question with something I was going to ask. You know, yesterday President Obama spoke at the State of the Union and talked about a middle class tax cut and he talked about funding colleges, community colleges, with free tuition. And I agree with both of those proposals. And he said that in doing that, he would get the money by asking the very wealthiest to pay just a little bit more.

You, Dr. Rivlin, just spoke about general tax revenues.

You know, it seems to me there is a lot here that we all agree on both sides of the aisle. We recognize that the SGR needs to be repealed and reformed, that it needs to be fixed permanently, and that this is a very good opportunity to fix Medicare. Joe Lieberman, I think, laid out a compelling case about if we just do nothing, we are really going to be in trouble.

And if we are going to be honest with each other, my colleagues, there is plenty of blame to go all around. On this side of the aisle, we won't even look at some of the things that people say we need to have if it is going to be balanced. And on the other side of the aisle, you won't even consider any kind of tax increases whatsoever. And the truth of the matter is we have to take our blinders off and kind of look and see.

I agree that the beneficiaries should not bear the major cost of it, but I wonder if you could, Dr. Rivlin, just elaborate a little bit on what you started to say in answer to the last question about general tax revenue, about changing some of that to get more money into the Medicare program.

Ms. RIVLIN. Well, I favor, as I said, comprehensive tax reform, and I think you can do that in a way that raises more revenues and is more progressive. That is an OK term. But I would caution this committee against getting too far afield. You have already done a really constructive piece of work in this tri-committee bill. Strengthen it; and pay for it; and pay for it in a way that accelerates the payment reform in Medicare and makes Medicare a more efficient program. And you can find various ways of doing that, but I wouldn't take on the burden of reforming the whole tax system in this context, because you have got a big opportunity to do something very important right here in this committee.

Mr. ENGEL. Well, I do think that if we are really going to hopefully down the road have a much greater fix, that we are going to have to talk and be honest about general tax revenues.

Senator Lieberman, I am wondering if you could elaborate a little bit more on, in your proposal, general tax revenues were not a part of this. Is there a reason why? And do you think we could combine the two———

Mr. LIEBERMAN. Right.

Mr. ENGEL [continuing]. And perhaps come up with a———

Mr. LIEBERMAN. Well, it is a good question. Thanks, Congressman.

We were working really as best we could within the system, so we added some progressive elements to it. I mean, we asked the people, based on income, to pay more for Part B and Part D. We set a limit of out-of-pocket expenses for people at $7,500, which was something I appreciated very much that Dr. Coburn was willing to support, but we raised that up to $22,500 for individuals who make more money. So we tried to be comprehensive about it, but I think the other thing that has to be recognized——I repeat myself, and I apologize——is that it is general revenues that are paying for most of Part B doctors and Part D prescription drugs now.

The system is a fairly progressive system now, not just the Medicare financing but our tax system overall. I am not against tax reform that in some ways makes it more progressive. But that has to result from a give and take in which both sides feel that they are getting something that they believe in.

Mr. ENGEL. And, just in conclusion, the truth of the matter is, I believe there are a lot of people on both sides of the aisle that have political courage to do the right thing, but you want to have the political courage and do the right thing if you know it is real.

Mr. LIEBERMAN. You know it is real.

Mr. ENGEL. It is real.

Mr. LIEBERMAN. I agree.

Mr. ENGEL. If you have political courage, but it is not real, it is really a lose-lose situation.

Mr. LIEBERMAN. Yes.

Mr. ENGEL. And I think, I hope that we can make this real, because we do know that this can't continue, and we don't want to hurt the beneficiaries. Thank you.

Mr. LIEBERMAN. I agree. It is great to see Mr. Kennedy here. There are some familiar names: Sarbanes, Matsui, Kennedy.

But Teddy used to always say that, with his members of his committee particularly in the last period of his life——Mike Enzi, pretty conservative Republican——if we agree on 60 percent or 70 percent or 80 percent on this given issue, let's do it. Let's forget about the other 40, 30, 20 percent. And President Reagan said that too. He would much rather get 50 percent of what he wanted rather than sort of hold his flag high while he was going over the edge of a cliff. That makes a lot of sense.

Mr. GUTHRIE. Thank you.

The gentleman's time has expired.

I recognize Mr. Griffith from Virginia.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate it. This is a marvelous panel. I appreciate listening to your testimony here today. I am proud of the work that we have done over the last 2 years, and hopefully we can finish it up this year.

One of the champions in that cause in leading the way has been Dr. Burgess of Texas, and I accordingly now yield my time to the good doctor.

Mr. BURGESS. Well, I thank the gentleman for yielding.

I just have a couple of follow-up things that I wanted to cover. And it is really too bad that Mr. Shimkus has left, because I wanted to give him some comfort that this actually———

Mr. SHIMKUS. I am watching you. I have got your back.

Mr. BURGESS [continuing]. That some of the changes that led to the SGR were actually implemented in Congress in 1988, and that led to the update adjustment factor that got us into some of this mess where we are. So I wanted to alleviate that burden from my friend from Illinois because I know he carries it around, and it is a very heavy burden.

I also want to address the issue of, we talk about how Medicare spending has been reduced. And, in many ways, it was a pleasant surprise in January of 2013 when the CBO came out and said, Hey, we put SGR repeal on sale. After the 2012 election, I had put a lot of hope in the fact that Governor Romney was going to win the election; Paul Ryan would be the vice president; we would have a full-throated implementation of premium support; and, over time, the SGR argument would simply go away, because premium support would replace it, there would no longer be a need for the SGR. Well, that didn't happen. But then the Congressional Budget Office came to the rescue of SGR reform and put it on sale.

But, yes, the recession may have caused part of that. The SGR itself may be responsible for some of the reduction. The Affordable Care Act, yes, it hadn't really been implemented for all that long. But, 10 years ago, Part D happened, and a lot of us argued prior to the passage of Part D that, hey, if we pay for the Lipitor, there may be fewer episodes of congestive heart failure requiring hospitalization. And it is, in fact, and I have not seen any study now of the 10-year effect. Here is an interesting point. We are almost at the 10-year point of the implementation of Part D. Has anybody

gone back and looked at what were the actual savings? We were all told what it was going to cost. It didn't cost that much.

But there were actually some benefits, because when Medicare originally passed, it paid for the doctor visit, it paid for the hospitalization, it didn't cover prescription drugs. My dad was a general surgeon. I used to tease him; I said, Well, back then, you only had two drugs, penicillin and cortisone, and they were interchangeable. I know. He didn't think it was funny either. But the prescription drug part of Medicare was an important change that needed to occur, and now we may be reaping the benefit from that.

But it would also be a shame to let this moment——I appreciate so much your forbearance and your indulgence today——to let this moment pass without fixing this. The gentlelady from Florida said, Well, last time you put a pay-for on it, it was untenable. Might I remind everybody, it passed the House with that offset. And we can do that again. There are actually more of us now than there were last March, and we can pass it in a partisan vote, if necessary, but how much better would it be if we all sat down and did that very, very difficult, very troublesome, very nettlesome work of providing the offset and made this a meaningful and lasting solution to a very nettlesome problem?

I will accept your observations.

Mr. LIEBERMAN. Well, I say, Amen, really. The other thing I would say, you make a really important point——and, obviously, not every prescription that everybody gets reimbursed through Part D is exactly necessary——but overall, to me, it just seems——and we don't really say this enough and appreciate it enough——axiomatic, really self-evident that the part of why, generally speaking, we are living longer is because of the positive impact of prescription drugs on the health of the American people, and Part D made those drugs much more accessible to many, many more people, millions more people.

Ms. RIVLIN. Yes. Well, I would add my amen too, and the hope, as I have said before, that you seize this opportunity to move ahead and make Medicare——put it on a track to becoming a more cost-effective program than it is because the pay-fors that have been suggested are not just beneficiary cuts. They really would move in the direction of making Medicare a more efficient program.

Mr. BURGESS. I thank my friend from Virginia.

I will yield back.

Mr. GRIFFITH. I yield back.

Mr. GUTHRIE [presiding]. Thank you, gentleman.

Time has expired.

Mr. Collins from New York is recognized.

Mr. COLLINS. Thank you, Mr. Chairman.

Since I am last, I will be as brief as I can, but as the junior Member here, in listening to this testimony, it has been an eye-opening discussion where we all agree that we need sustainability and we can't keep kicking the can, as we have done with the SGR doc-fix that, Senator, you called broken and needs to be done away with.

So here is my real question. I think what we are talking about is access. The difficulty of Medicaid is access. The doctors aren't paid much. Therefore, doctors don't see Medicaid patients. The fear

of the SGR implementation would be if a 21-percent cut took place, access would be problematic for our seniors. So that is——the overarching piece is access, and now we are into the details of pay-fors. And I certainly agree with Mr. Shimkus: Let's make sure this is real, and it doesn't add to the deficit and debt that our children are inheriting from us.

So my question really, Dr. Rivlin, would be, when I look at our new program, a half of 1 percent increase for 3 or 4 years, then freezing that for the next 5 years, I am seeing a lot of long-term projections here that are talking about increases; we will fix it now, but then the increases the docs will see half of 1 percent a year, maybe 1 percent a year.

Now, if we are in the inflationary environment we are today, which is all but no inflation, that is one thing, but I am curious, because you have spoken about access before all the way back to 2002 when we first were facing a potential 2 percent cut, what do you think about the new payment plan and the fact that the increases are very small for the next 10-plus years, and could we be back having this discussion if inflation were to take off in any way? So just curious of your take on that.

Ms. RIVLIN. You could be. I don't see inflation as an imminent threat. And long before inflation generally comes back, I think you could get the whole health system on a better track such that almost everybody, and I don't mean just Medicare beneficiaries, was in some kind of integrated health plan that was coordinating their care and giving them as good care as they could get but not wasteful and excessive care.

Mr. COLLINS. Yes.

Ms. RIVLIN. But I think you can move in that direction and that you have a way to do that starting with this bill that you have.

Mr. COLLINS. Thank you.

Senator, do you have any thoughts on that?

Mr. LIEBERMAN. Well, I agree that this is the moment.

Mr. COLLINS. No. My question was, are we at all at risk, do you think, fixing it now and we would be done with it———

Mr. LIEBERMAN. Right.

Mr. COLLINS [continuing]. But then the payment schedule set going forth has such small increases———

Mr. LIEBERMAN. Oh, you mean in the current SGR replacement?

Mr. COLLINS. Yes. Are we opening the door to a problem down the road?

Mr. LIEBERMAN. It is possible, but I tell you, you have done something so significant that so improves on the status quo, and the repeated crises that called for the doc-fixes and the contortions that that invited here in both Houses of Congress by Members of both parties who took advantage of it and created a mess, really, in the public view, on balance, I don't have any hesitation to say that I think what you have done is worth supporting.

It is not perfect, but when was the last time any of us did anything perfect? It is an improvement, and it is a bipartisan, bicameral improvement. And Lord knows, it might just start a cycle of virtue here in accomplishment in Congress that would go on to other areas as well.

The people really need to be given a basis for hope, honestly, and you can begin it right in this subcommittee.

Mr. COLLINS. Well, I agree.

Your testimony has all been great today, and I personally want to thank you for staying over an extra half-hour, 45 minutes while we did this.

And thank you, Chairman. I yield back.

Mr. GUTHRIE. Thank you.

The gentleman yields.

We really do appreciate the panel, it was outstanding, outstanding testimony and very informative, and we do have a lot of work ahead of us.

All members have been recognized. I want to remind the members they have 10 business days to submit questions for the record.

And I ask the witnesses to respond to the questions promptly.

And members should submit their questions by the close of business on February the 4th, 2015.

And, without objection, the subcommittee will stand in recess until 10:15 tomorrow morning.

Without objection, so ordered.

[Whereupon, at 12:46 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

January 20, 2015

The Honorable Fred Upton, Chairman
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Ranking Member
Energy & Commerce Committee
United States House of Representatives
Washington, DC 20515

The Honorable Joe Pitts, Chairman
Energy & Commerce Committee
Subcommittee on Health
United States House of Representatives
Washington, DC 20515

The Honorable Gene Green, Ranking Member
Energy & Commerce Committee
Subcommittee on Health
United States House of Representatives
Washington, DC 20515

Dear Chairman Upton, Ranking Member Pallone, Chairman Pitts and Ranking Member Green:

The undersigned organizations share a commitment to advancing the health and economic security of older adults, people with disabilities and their families. We are writing to submit a formal statement for the Januar 21 and 22, 2015 Health Subcommittee hearing, "A Permanent Solution to the SGR: The Time Is Now."

The Sustainable Growth Rate (SGR) formula must be replaced, and we urge Congress to enact a permanent solution for the critical health care "extenders" that have traditionally ridden on bills to patch the SGR payment system. In the absence of a permanent SGR solution, we believe that Congress must enact a temporary patch to avoid drastic cuts in Medicare physician payment, and to ensure that equal extensions are granted for programs and policies critical to the health and well-being of Medicare beneficiaries, including the Qualified Individual (QI) program, outpatient therapy caps, low-income outreach and enrollment assistance and the Aging and Disability Resource Centers (ADRCs).

The SGR formula is fundamentally flawed and permanent changes to the Medicare reimbursement system are long overdue. Congress has been forced to enact 17 temporary legislative patches since 2003, creating unnecessary uncertainty for providers. Recent bipartisan proposals to fix the SGR begin moving the current volume-based payment system towards one that incentivizes quality, efficiency and innovation.

While it is in the best interest of Medicare beneficiaries and their doctors to find a permanent SGR solution, an SGR fix should not increase the burden of health care costs for people with Medicare, jeopardize access t needed care, or worsen the already tenuous economic circumstances facing many people with Medicare. Hal of all Medicare beneficiaries—more than 25 million older adults and people with disabilities—live on annua incomes of $23,500 or less, and one quarter live on $14,400 or less.[1] Most people with Medicare cannot afford to pay more for health care, and we oppose proposals that would shift additional costs onto them.

Additionally, any SGR solution, either permanent or temporary, must include a matching fix for key extenders policies, which are historically addressed by Congress alongside SGR patches. Specifically, we support making the expiring QI program permanent. The QI program provides needed Part B premium

[1] Jacobson, G., Huang, J., Neuman, T., and K.E. Smith, "Income and Assets of Medicare Beneficiaries, 2013 – 2030," (Kaiser Family Foundation: January 2014), available at: http://kff.org/report-section/income-and-assets-of-medicare-beneficiaries-2013-2030-issue-brief-savings-of-medicare-beneficiaries/

assistance to low-income Medicare beneficiaries with incomes from 120% to 135% of the federal poverty level—about $14,000 to $15,750—and less than $7,160 in assets for an individual. Failure to make the program permanent would seriously threaten vulnerable Medicare beneficiaries' economic security and access to physicians. In addition, in the absence of full repeal of Medicare outpatient therapy caps, we support making the exceptions process permanent. Finally, we support permanently extending funding for critical community-based resources that are also expiring. This includes outreach and enrollment assistance to low-income Medicare beneficiaries and ADRCs, the "no-wrong door" network of long-term care services and supports information and referral services.

As another SGR deadline approaches, we hope you will act to replace the SGR, and we urge you to enact permanent solutions for health care extenders policies that are vital to the health and financial well-being of people with Medicare. Thank you.

Sincerely,

AFL-CIO
AFSCME
Alliance for Retired Americans
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Association on Health and Disability
B'nai B'rith
Center for Elder Care and Advanced Illness
Center for Medicare Advocacy, Inc.
Medicare Rights Center
National Academy of Elder Law Attorneys
National Adult Day Services Association
National Association of Geriatric Care Managers
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Senior Citizens Law Center
OWL – The Voice of Women 40+

STAND FOR QUALITY
in Health Care

The Honorable Joe Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Gene Green
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
2322A Rayburn House Office Building
Washington, D.C. 20515

January 21, 2015

Dear Chairman Pitts and Ranking Member Green:

Stand For Quality (SFQ), a coalition of diverse private health care organizations, including physicians, nurses, hospitals, payers and consumers, commends the Committee on Energy and Commerce for its continued focus on Medicare payment reform and permanent repeal of the Medicare Sustainable Growth Rate (SGR). SFQ strongly supports repealing the Medicare SGR and transitioning to a payment system that bases physician reimbursement on the quality of care provided, thereby ensuring greater value for our health care dollars. Given that the private sector often mirrors Medicare's payment structure, creating a value-driven payment system in Medicare could also have positive implications for the rest of the health care system.

We commend the Committee's intent to move Medicare physician reimbursement away from the volume-based fee-for-service model and towards a payment system that rewards quality. Successful reform, however, will require engagement and buy-in from a broad range of health care stakeholders, including consumers. It is therefore critical that the Committee not only consider diverse viewpoints during the policymaking process; the Committee must also ensure that continued multi-stakeholder participation is preserved in and supported by the accountability framework that replaces the Medicare SGR.

Specifically, we strongly encourage the Committee to ensure that final legislation to repeal the Medicare SGR and replace it with a merit-based incentive payment system explicitly provides for multi-stakeholder input into the quality measures used to measure the performance of participating Medicare providers. Indeed, quality measurement in final SGR reform legislation must actively engage not just those who deliver the care, but also those who receive care and pay for care, as well as other stakeholders.

Quality measurement and reporting is a foundational building block for improving the quality and value of health care in the United States: we cannot improve what we do not measure. Measuring and reporting on health care quality sheds light both on best practices and on what needs improving. Increased application of quality measurement and reporting across health care settings has already led to improved

health outcomes and lowered costs. For example, we have seen decreases in the rates of health care acquired conditions, such as Central Line Blood Stream Infections. Central Line Blood Stream Infections have declined in hospital Intensive Care Units, and this measure is now being expanded to all areas of the hospital. Another example of a high-impact quality measure is measuring early elective inductions: reducing elective early inductions before 39 weeks gestation has resulted in better health outcomes for women and newborns and generated significant cost savings. Indeed, reports issued by the U.S. Department of Health and Human Services show that quality measurement, reporting, and improvement initiatives have resulted in reductions in adverse drug events, falls, infections, and other forms of hospital-induced harm, preventing thousands of deaths in hospitals and patient injuries.[1] Quality measurement is most effective when it is both informed by and accepted by all stakeholders in health care delivery: those who provide health care services, those who receive them, and those who pay for care.

Ensuring multi-stakeholder participation in the selection and application of quality measures is critical. Processes that facilitate multi-stakeholder participation, such as quality measure endorsement and the Measures Application Partnership (MAP) pre-rulemaking advisory body, help promote utilization of high-quality measures, alignment of measures across public and private sectors, and broader use by payers and consumers. Moreover, the endorsement and MAP processes facilitate transparency and provide consumers with critical opportunities to ensure that their perspectives are heard by providers and the health care system that is intended to meet their needs. Absent the endorsement and MAP processes, consumers have limited ability to advocate for the measures and quality information that is most useful to them and helps them make better decisions about their health and health care.

In final legislation to repeal the Medicare SGR and replace it with a merit-based incentive payment system, we hope to see strong emphasis on the use and reporting of multi-stakeholder endorsed measures and a continued commitment to utilizing the MAP pre-rulemaking function in the development of quality measure sets for participating Medicare providers. Ensuring that these processes are able to function at their highest potential also requires sustained federal investment. To this end, we request sustained funding for a consensus-based entity responsible for, amongst other activities, convening the multi-stakeholder endorsement and MAP processes.

Thank you for your consideration. We look forward to partnering with you to transition Medicare to value-based payment models that support delivery of high-quality, patient-centered care and promote improved transparency and accountability in our nation's health care system.

Sincerely,

Charles N. Kahn III
SFQ Co-Chair
President & CEO
Federation of American Hospitals

Debra Ness
SFQ Co-Chair
President
National Partnership for Women & Families

[1] U.S. Department of Health and Human Services, "New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings." (May 2014) Available at http://innovation.cms.gov/Files/reports/patient-safety-results.pdf.

Federation of
American
Hospitals

Charles N. Kahn III
President and CEO

January 21, 2015

Chairman Fred Upton
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Frank Pallone
House Energy and Commerce Committee
U.S. House of Representatives
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Subcommittee Chairman Joe Pitts
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Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
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Ranking Member Gene Green
House Energy and Commerce Committee
Subcommittee on Health
U. S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton, Subcommittee Chairman Pitts, Ranking Member Pallone, and Subcommittee Ranking Member Green:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH welcomes the opportunity to submit our views concerning the sustainable growth rate ("SGR") reform, and commends the Subcommittee's leadership in addressing this problem. We also applaud the Subcommittee's interest in building upon the bipartisan, bicameral agreement on policy reached in the 113th Congress and discussing options to permanently resolve this issue in a fiscally responsible manner.

In order to serve our patients' needs, America's hospitals rely on the quality and professionalism of their medical staffs. The partnership we have long shared with physicians has ensured that seniors and patients in communities across America have access to the medical care they need when they need it. Going forward, we will strengthen this partnership to improve the performance of hospitals and the health care system more generally, and expand access and deliver higher quality care more efficiently – goals we all share. One of the greatest threats to this partnership and achievement of these goals, however, is the lack of fair and predictable Medicare payment for physicians. That is why the FAH remains deeply concerned with the problems plaguing the SGR formula.

The FAH strongly supports fixing Medicare's flawed physician payment system, and as the Subcommittee moves forward to address the SGR, the FAH urges that a new approach include the principles outlined below.

KEY PRINCIPLES FOR REFORMING PHYSICIAN PAYMENT AND THE SGR

- ***The SGR Fix Should Not Be Funded with Cuts in Payments for Hospital Services***

The FAH vigorously opposes funding the SGR fix with cuts in payments for critical hospital services. Should Congress determine that offsets are needed for an SGR fix, we strongly encourage the Subcommittee to look at other sources of savings to cover the cost of a Medicare physician payment solution.

Stable and adequate Medicare payment, for both physicians and hospitals, is essential to sustain this partnership and our shared goals of broad access to high quality care, as well as to align incentives in a new world of greater care coordination and integration. It is counterintuitive to reduce Medicare or Medicaid payments to hospitals, which already fall far below the cost of care, to offset the costs of fixing the SGR. Robbing hospital Peter to pay physician Paul is bad public policy and severely undermines the Subcommittee's expressed goal of resolving this issue in a fiscally responsible manner. Since 2010, hospitals have been hit with $121.9 billion in federal Medicare and Medicaid payment cuts, which will occur over ten years. Last year, the Medicare Payment Advisory Commission ("MedPAC"), which advises Congress on Medicare payment policy, projected that hospitals would experience the lowest Medicare margin in history for 2014: negative 8 percent. And just last month, MedPAC delivered even more sobering news: for 2015, MedPAC now projects that Medicare hospital margins will set a new low of negative 9 percent. At a time when health care spending is experiencing an unprecedented slowdown, enough is enough. Hospitals are working diligently to protect patient access to care, and we cannot do that in an environment of continued cuts.

Further, these cuts have occurred at the same time as the underlying cost drivers of hospital care continue to climb. It is unfair and unwise to expect the health care system or one element of the system, such as hospitals that already suffer from chronic federal underfunding, to finance the cost of past policy mistakes.

- ***Ensure Fair and Equitable Payment***

We agree with many in the physician community that an adequately funded Medicare physician payment system is needed, while creating incentives for physician participation in an array of alternative payment models focusing on value rather than volume. This will provide the basis for a new payment and delivery system that improves quality and increases efficiency.

Congress must recognize, however, that adequate funding for physician services depends on the setting in which those services are furnished. Such funding should not jeopardize access to hospital services, which have intrinsically higher costs due to the need for round-the-clock, comprehensive emergency care every day of the year for patients who often are sicker and suffer with higher average risk for complications than patients treated in a physician's office.

- ***A Flexible Transition Period Is Needed***

In developing a new Medicare physician payment system, the FAH supports a transition period during which physician practices have the opportunity to adopt varying new payment and delivery models, scalable to their practice, and at an appropriate pace. This will provide physician practices with the flexibility needed to plan for infrastructure and other changes, and join new care delivery models as the practice becomes ready.

- ***Timely Data and Feedback is Needed***

The FAH supports requiring the Centers for Medicare and Medicaid Services ("CMS") to provide timely feedback, at least quarterly, and actionable, real time and relevant data to physicians that will assist physicians in making necessary adjustments in their medical practice to improve patient care. We also generally support expanded use of Medicare data for physician performance improvement, as this will help physicians better incorporate practice improvements, so long as appropriate safeguards are present to ensure, for example, that data are adequately risk-adjusted and appropriately attributed to those who have provided the medical care.

- ***Align Incentives to Encourage Coordinated Care***

The FAH supports continued efforts to align incentives for coordinated care across providers. Effective coordination and collaboration among hospitals, physicians and other providers will help achieve higher quality of care with better outcomes, and for better value, in a more seamless manner.

- ***Assess Payment and Delivery Development Efforts to Ensure Proper Long-Term Implementation***

As numerous innovative payment and delivery models get underway, it is critical to assess "best practices" over time and build upon the experience of successful payment and delivery models. Therefore, the FAH supports an ongoing assessment of efforts to develop new payment and delivery models, including annual reports to Congress. It would be short-sighted to jump to long-term payment and policy decisions without the benefit of knowledge and "lessons learned" from the testing phase of various new payment and delivery models. There are many initiatives currently underway by CMS's Center for Medicare & Medicaid Innovation and in the private sector that hopefully will provide a base of data and experience to help craft appropriate, permanent policies.

- ***Quality Measures Should be Reviewed and Developed through a National, Multi-Stakeholder Consensus Process***

For more than a decade, the FAH has been working side-by-side with other stakeholders toward three quality goals: improving quality of care; making provider performance more transparent; and improving the value of health care services as measured by both cost and quality. More specifically, the FAH has been engaged in multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and private quality reporting and payment programs. These processes include purchasers, payers, providers, consumers, employers, physicians, researchers,

governments and other stakeholders to support improvement in health care quality and outcomes while achieving better value for the services provided. These groundbreaking efforts, over many years, have produced a reliable multi-stakeholder, consensus-based quality framework designed to address national goals and priorities outlined in the federal government's National Quality Strategy ("NQS").

The NQS reflects the multi-stakeholder consensus that a patient-centered health care system will lead to improved population health, with more efficient care delivery, at a lower cost. To help achieve the NQS, the National Quality Forum ("NQF") convenes multi-stakeholder consensus development committees for evaluating, endorsing, and recommending quality measures for use in public reporting and payment programs. The NQF quality measure endorsement process ensures that measures are vetted through a multi-stakeholder process that assesses the importance of topics to measure, and the scientific soundness, reliability, and feasibility to collect and report the data. In order to drive transparent quality improvement, metrics must be understandable to patients and their families and providers, instead of just a matter of academic interest.

The NQF also convenes the Measure Applications Partnership ("MAP"), a separate multi-stakeholder process. The purpose of the MAP is to provide advice and assess specific quality measures for their readiness for specific federal public reporting and payment accountability programs prior to the measures being included in a proposed rulemaking issued by HHS. The pre-rulemaking review makes the rulemaking process more efficient and gives clinicians and providers the opportunity to better prepare for the implementation of new quality measures.

To be effective, quality measures must produce results that are meaningful for patients, payers, providers, clinicians and other quality enterprise stakeholders. The measure endorsement and pre-rulemaking review process for appropriate use of measures in specific quality programs is critical for ensuring alignment of public quality reporting and payment programs across various providers, as well as the reliability, validity and usefulness of quality measures. The consensus-based review process also influences the private sector use of quality measures.

Both the NQF measure endorsement process and the MAP provide proven processes for engaging strong multi-stakeholder efforts and consensus building. Involving multiple stakeholders in the approval process creates a level playing field, reduces reporting burden, helps assure broad acceptance of the measures for use by both public and private payers and by consumers and patients, and creates efficiencies by minimizing duplication of effort. Without these processes, the system risks returning to fragmented past practices with less consensus and alignment among quality programs in both the public and private sectors.

The bipartisan, bicameral agreement on physician payment policy reached in the 113th Congress proposes streamlining existing physician quality programs, and the FAH supports such streamlining in concept. ***Yet, it is critical that the development of a new streamlined program, whether a VBP or other quality program, incorporate existing quality infrastructures, such as the NQF and the MAP, that have been so instrumental in facilitating Medicare quality programs and streamlining measures for all providers. We urge the Subcommittee to ensure that quality measures used in any quality or VBP program are those that are endorsed through the NQF.*** Further, the HHS Secretary's annual

solicitation of recommended measures for inclusion in the VBP program should utilize the existing MAP process.

Additionally, the FAH has concerns about proposals involving physician-endorsed measures and allowing individual physician specialties to develop measures, which may not necessarily be reviewed and endorsed through the national NQF and MAP consensus processes. We caution the Subcommittee that permitting various stakeholders to individually develop and use their own measures without having those measures reviewed by an impartial multi-stakeholder entity would lead to questions about the validity, reliability and usefulness of the data produced. It could also create a proliferation of inconsistent, conflicting, and duplicative measures that will be burdensome, confusing and even harmful to patients and health care providers who need to rely on consistent and accurate data at the point of care. It certainly would add to the overall costs in the health care system and undermine the goals of improved health, improved care delivery and lower costs.

While it is critical that physicians be involved with the development of the measures on which they will be evaluated, it is equally critical that physician measures reflect the goals of the NQS and that the process for developing, endorsing and implementing quality measures involve a broad range of health care stakeholders. Consistency of measurement across providers and settings will be jeopardized without the use of measures endorsed through a multi-stakeholder process, such as the NQF. All stakeholders should have the opportunity to review any quality measure for its scientific validity, feasibility, reliability and importance to measurement. Such a process ensures that quality measures used for public reporting and payment will be valid for purposes of accountability and comparison.

Both the NQF and the MAP provide a proven process for engaging strong multi-stakeholder efforts and consensus building. These processes permit wide vetting of the measures by multiple stakeholders based on criteria for importance, validity, reliability, solid evidentiary base, and usability. Involving these multiple stakeholders in the approval process creates a level playing field, reduces reporting burden and helps assure broad acceptance of the measures for use by both public and private payers and by consumers. Without these processes, we risk returning to fragmented past practices that had less consensus and alignment among quality programs in both the public and private sectors.

Also, because the NQF and MAP processes promote achieving consensus on measures at the front-end, providers have more time to plan how to implement and use measures. This means that when measures are ready for implementation, this can be achieved in a more efficient and meaningful manner.

Further, the FAH recommends that as measures are developed and endorsed through a multi-stakeholder consensus process, the measures should be specified to coding systems that are expected to be in use during the time period for which the measures will be effective. This will help ease administrative difficulties in aligning measures to appropriate coding systems, which will further ensure the availability of a measure.

With respect to the development of measures, we support additional funding for measures, and also urge that continued funding be provided for the measure endorsement and MAP pre-rulemaking processes as well.

Finally, the FAH also cautions the Subcommittee concerning the use of registries. We recognize that there is valuable role for registries, but we urge the Subcommittee to ensure that registry measures are required to be reviewed and endorsed through a multi-stakeholder consensus process. Further, because registries are expensive to develop and maintain, participation in a registry should be optional. We urge the Subcommittee also to keep in mind that registries may take many years to develop, and the promise of their ultimate long-term functionality and financial sustainability remains to be seen. Therefore, the Subcommittee should consider the return on investment when developing proposals involving registries and ensure that other alternative avenues are available to participate in quality programs.

****

We thank the Subcommittee for its leadership and efforts to address these important Medicare physician payment matters. We look forward to continuing our work with the Subcommittee and Congress to meet the challenge of ensuring adequate payments for physicians and to strengthen, not weaken, the ability of hospitals to sustain America's fiscal and public health, while providing patient-centered quality of care.

Sincerely,

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Comments of the American College of Clinical Pharmacy

Submitted to the
Committee on Energy and Commerce
Health Sub-Committee
United States House of Representatives

"A Permanent Solution to the SGR:
The Time is Now"
January 21-22, 2015

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The American College of Clinical Pharmacy (ACCP) appreciates the opportunity to provide the following statement for the House Energy and Commerce Health Subcommittee hearings on the issue of Medicare physician payment reform and needed changes to the Sustainable Growth Rate (SGR) formula.

These comments are consistent with information provided last year during consideration by the Committee of proposed legislation on this issue. We applaud the leadership of the Committee in moving swiftly in the 114th Congress to address this fundamental issue in assuring the quality, sustainability, and effectiveness of the Medicare program going forward.

ACCP is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of over 15,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy. We are joined in these comments by the College of Psychiatric and Neurologic Pharmacists (CPNP), with whom we work closely on policy issues related to Medicare payment policy reform, benefit re-design, and care delivery transformation.

We fully support the continuing efforts of the Committee in seeking to address the flaws of the current volume-based physician/provider payment system and to develop meaningful reforms that achieve better care for Medicare patients as well as longer-term economic viability of the Medicare program. In order to enhance access to high-quality care and to ensure the sustainability of the Medicare program as a whole, it is essential that progressive payment and delivery system improvements that have emerged and are being actively utilized in both public- and private-sector integrated care delivery systems be facilitated and aggressively promoted -- especially those that measure and pay for quality and value, not simply volume of services, and that fully incentivize care that is patient centered and team based.

To that end, ACCP is dedicated to advancing a quality-focused, patient-centered, team-based approach to health care delivery that helps assure the safety of medication use by patients and that achieves medication-related outcomes that are aligned with patients' overall care plans and goals of therapy. Clinical pharmacists, working collaboratively with physicians and other members of the patient's health care team, utilize a consistent process of direct patient care that enhances quality and safety, improves clinical outcomes and lowers overall health care costs.

As the committee continues its effort to develop and adopt payment approaches that link closely to current and evolving value and quality objectives, ACCP urges you to include payment mechanisms and incentives that promote a truly patient-centered and inter-professional approach to medication-related clinical care and medication safety. Such measures should encourage broader adoption of the team-based service of comprehensive medication management (CMM) that is supported by the Patient-Centered Primary Care Collaborative, (PCPCC), in which ACCP as well as the major primary care medical organizations are actively involved. CMM helps ensure that seniors' medication use is effectively coordinated, and in doing so enhances seniors' health care outcomes, contributing directly to Medicare's goals for quality and affordability. CMM can **"get the medications right"** as part of an overall effort to improve the quality and affordability of the services provided to Medicare beneficiaries.

This is particularly critical for seniors, due to the essential role that medications play in their care and treatment:

- The typical Medicare beneficiary sees two primary care providers and five medical specialists in any given year. Four of every five medical encounters result in a prescription order (new or refill);
- 66% of Medicare beneficiaries have two or more chronic diseases; 40% have four or more;
- 60% of seniors are taking 3 or more discrete prescription or non-prescription medications at any point in time.
- Medications are the fundamental treatment intervention in each of the eight[1] most prevalent chronic conditions in Medicare patients based on the most recent data from the Centers for Medicare and Medicaid Services (CMS).

In "getting the medications right," CMM also contributes to enhanced productivity for the entire health care team, allowing other team members to be more efficient in their own particular patient care responsibilities. Physicians and other team members are freed up to practice at the highest level of their own scopes of practice by fully utilizing the qualified clinical pharmacist's skills and training to coordinate the medication use process as a full team member.

In summary, as part of the process of reforming the Medicare payment system, Congress should enact reforms to the Medicare Part B program that provide for coverage of CMM services provided by qualified clinical pharmacists as members of the patient's health care team within its broader payment reform efforts. We would welcome the opportunity to provide further information, data, and connections with successful practices that provide CMM services to help further inform the committee about this service in the context of Medicare payment and delivery system improvements that will modernize and sustain the program for the future.

[1] High blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression.

THE EVIDENCE FOR VALUE OF COMPREHENSIVE MEDICATION MANAGEMENT SERVICES: "GETTING THE MEDICATIONS RIGHT" RESOLVES REAL PROBLEMS AND IMPROVES OUTCOMES

Growing evidence demonstrates the care quality and economic benefits of a **comprehensive approach to team-based medication management**. It also reveals that some commonly cited "medication problems" for patients, including seniors, are often not the leading reasons for treatment failures and incomplete achievement of clinical goals. "Medications" include prescription and non-prescription products, herbals, and vitamins/supplements.

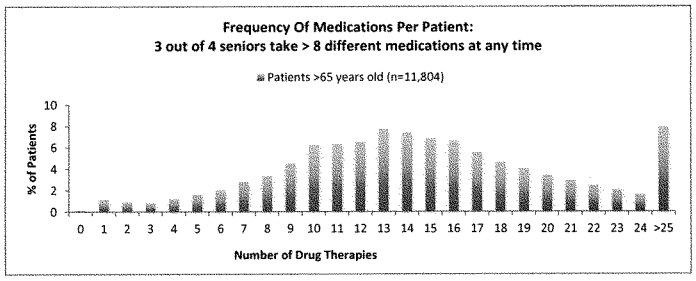
The data represented below reflect aggregated results from 19 distinct medication management service practices, provided by qualified pharmacists within settings such as community-based pharmacies, hospital-based clinics, free-standing medical clinics, and health systems. In all cases, a consistent and comprehensive process of care was used in the provision of the service. Data reflect 11,804 patients (over 65 years old) with 21,213 documented encounters. All patients received services between April 2006 and September 2010.[1]

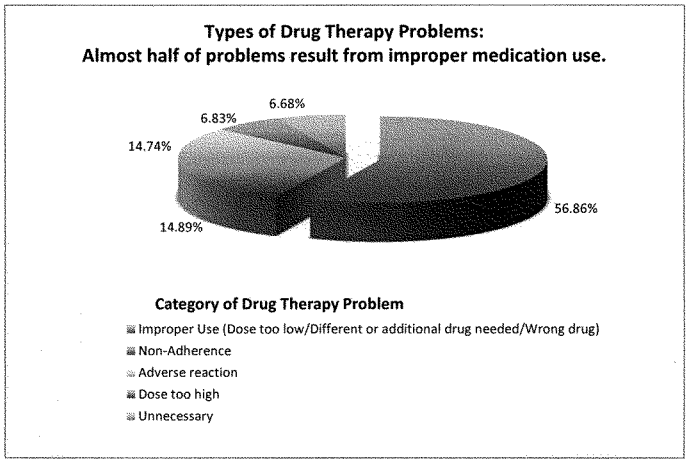
2 out of 3 Medicare Beneficiaries Need Access to Comprehensive Medication Management (CMM) Services

Of the 11,804 patients documented, 2 out of 3 seniors had 3 or more medical conditions and 2 out of 3 seniors were identified with 2 or more drug therapy problems.

Providing coverage for CMM services could help the Medicare program avoid:

Almost 6 million physician office visits, saving more than $1 billion annually
670,000 emergency room visits, saving more than $500 million annually





HEALTH CARE SERVICES SAVINGS FROM CMM SERVICES

	11,804 patients (over 65 years old) 21,213 encounters			Medicare Part B Population Projections	Medicare Part B Population Projections**
Health care savings*	# of events avoided	# of referrals	$ net savings	# of events avoided	$ Gross Savings
Office visit ($182)	9,146	838	$1,512,056	23,789,053	4,329,607,646
Specialist visit ($564)	549	149	$225,600	1,427,967	805,373,388
Urgent care ($182)	263	7	$46,592	684,072	124,501,104
Emergency department visit ($821)	1,033	12	$838,241	2,686,868	2,205,918,628
Hospital admission ($29,046)	69	15	$1,568,484	179,471	5,212,914,666
Totals			$4,190,973		

*Health care event savings and referral costs based on 2008 U.S. averages from Expenses per Visit for Ambulatory Visits and Inpatient Stay for 2008, Agency for Healthcare Research & Quality-Center for Financing, Access, and Cost Trends, 2010 and Genworth 2011 Cost of Care Survey, Genworth Financial 2011.

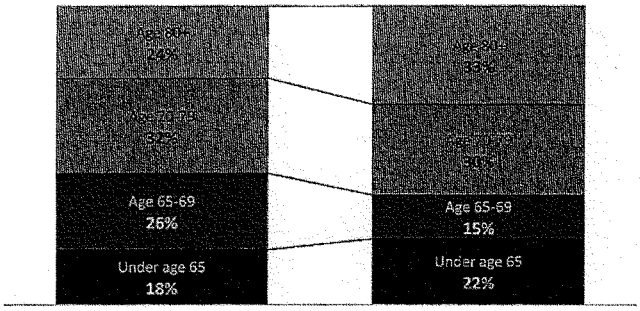
** Projections based on data collected over period: April 2006 to September 2010

(Endnotes) 1 Cipolle RJ, Strand LM, Morley PC. Pharmaceutical Care Practice: The Patient-centered Approach to Medication Management Services. 3rd edition. Copyright © 2012 by McGraw-Hill Companies, Inc

Exhibit I.1

People ages 80 and older accounted for 24 percent of the Medicare population and 33 percent of Medicare spending in 2011

Distribution of traditional Medicare beneficiaries and Medicare spending, 2011



Share of beneficiaries
Total number of beneficiaries in traditional Medicare: 38.3 million

Share of spending
Total spending for beneficiaries in traditional Medicare: $375 billion

NOTE: Analysis excludes beneficiaries with Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of a 5 percent sample of Medicare claims from the Chronic Conditions Data Warehouse, 2011.

Exhibit I.1: People ages 80 and older accounted for 24 percent of the Medicare population and 33 percent of Medicare spending in 2011

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

December 19, 2012

Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave.
Washington D.C. 20201

Dear Secretary Sebelius,

Pursuant to section 3210 of the Patient Protection and Affordable Care Act (ACA) you have requested the National Association of Insurance Commissioners (NAIC) to review and revise the NAIC Medicare supplement insurance (Medigap) model regulation to include nominal cost sharing in Medigap Plans C and F to encourage the use of appropriate physicians' services under Medicare Part B. Section 3210 directs the NAIC to base these revisions on evidence published in peer-reviewed journals or current examples used by integrated delivery systems.

Consistent with the process established by the Social Security Act for changes to Medigap standards, the NAIC appointed the Medigap PPACA (B) Subgroup (Subgroup) comprised of state insurance regulators, representatives from the Centers for Medicare and Medicaid Services (CMS), insurers and trade associations, consumer advocates, and other experts in the areas of Medicare and Medigap.

The NAIC has performed its requested review of the standards for Plans C and F under Section 3210 of the ACA. We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost sharing be introduced to Plans C and F. We hope that you will agree with this determination.

Medigap is a product that has served our country's Medicare eligible consumers well for many years, offering them security and financial predictability with regard to their Medicare costs. Medigap's protections are now inappropriately being held responsible for encouraging the overuse of covered services and increasing costs in the Medicare program.

We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services.

The statute requires the NAIC to base nominal cost sharing revisions on "peer-reviewed journals or current examples of integrated delivery systems". However, the Subgroup discovered that there is a limited amount of relevant peer-reviewed material on this topic. None of the studies provided a basis for the design of nominal cost sharing that would encourage the use of appropriate physicians' services. Many of the studies caution that added cost sharing would result in delayed treatments that could increase Medicare program costs later (e.g., increased expenditures for emergency room visits and hospitalizations) and result in adverse health outcomes for vulnerable

populations (i.e., elderly, chronically ill and low-income). Most of the studies do not consider the same population of health insurance beneficiaries as those that purchase Medigap products.

The Subgroup also gathered information from integrated delivery systems (Medicare Advantage plans) but concluded that, because these managed care plans make medical necessity determinations for Medicare, any such practices were not directly relevant for Medigap.

Also, as you know, significant new changes to Medigap plan offerings were implemented recently in 2010 which introduced new plans with increased beneficiary cost sharing. Plan M, which requires 50% beneficiary cost sharing on the Medicare Part A deductible, and Plan N, which requires a $20 copay for physician office visits and a $50 copay on emergency room visits, were introduced. We are still learning the impact of these new offerings on both the Medigap market and to the Medicare program.

Therefore, we hope you will agree with our recommendation that no changes should be made to Plans C and F at this time. However, we recognize that you may find that the addition of nominal cost sharing is necessary to implement Section 3210. If that is your decision, please know that the Medigap PPACA (B) Subgroup conducted extensive work in this area and voted on possible areas for revision that should serve as the basis for any further work on the issue, pending your determination on the need for additional action. The findings and work products of the Subgroup, which have not been adopted through the full NAIC process, are publicly available on their web page.

As always, the NAIC stands ready to continue it regulatory role in developing Medicare supplement standards and to assist you in any way possible.

Respectfully submitted,

Kevin M. McCarty
NAIC President
Florida Insurance Commissioner

James J. Donelon
NAIC President-Elect
Louisiana Insurance Commissioner

Adam Hamm
NAIC Vice President
North Dakota Insurance Commissioner

Monica J. Lindeen
NAIC Secretary-Treasurer
Montana Commissioner of Securities & Insurance

Sandy Praeger
Commissioner, Kansas Department of Insurance
Chair, NAIC Health Insurance and Managed Care Committee

A PERMANENT SOLUTION TO THE SGR: THE TIME IS NOW, DAY 2

THURSDAY, JANUARY 22, 2015

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

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Barton, Murphy, Burgess, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Schakowsky, Butterfield, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Clay Alspach, Chief Counsel, Health; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Robert Horne, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Michelle Rosenberg, GAO Detailee, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Greg Watson, Staff Assistant; Ziky Ababiya, Minority Policy Analyst; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Ashley Jones, Minority Director, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

Mr. PITTS. Ladies and gentlemen, we have floor votes coming up, so we are going to get started. The subcommittee will now come to order.

Today is the second day of our 2-day hearing on the permanent solution to the SGR. Yesterday we heard from a distinguished panel of experts on SGR financing issues. Today we have a panel of interested stakeholders.

Before I do that, we have a UC request, and I ask for unanimous consent to include the following statements for today's hearing record from the American Academy of Family Physicians and the American Ambulance Association. Without an objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have on our second panel today six witnesses. Mr. Richard Umbdenstock, president and chief executive officer of the American Hospital Association. Dr. Geraldine O'Shea, first vice president of the American Osteopathic Association Board of Trustees. Dr. Alan Speir, the medical director of Cardiac Surgical Services for Inova Health System and the chair of the Workforce on the

Health Policy, Reform, and Advocacy for the Society of Thoracic Surgeons. Dr. Ken Miller, board president of the American Association of Nurse Practitioners. Dr. Barbara McAneny, chair of the American Medical Association's Board of Trustees and CEO of the New Mexico Oncology Hematology Consultants; and Mr. Eric Schneidewind, president-elect of AARP.

Hope I didn't butcher your names too much. But thank you for coming today. Thank you for testifying. Your written statements will be made a part of the record. You will each be given 5 minutes to summarize your testimony, and your entire written statement will be made a part of the hearing record.

So we will begin with you, Mr. Umbdenstock. You are recognized for 5 minutes for your summary.

STATEMENTS OF RICHARD UMBDENSTOCK, PRESIDENT AND CEO, AMERICAN HOSPITAL ASSOCIATION; DR. GERALDINE O'SHEA, FIRST VICE PRESIDENT, AOA BOARD OF TRUSTEES, AND MEDICAL DIRECTOR, FOOTHILLS WOMEN'S MEDICAL CENTER IN CALIFORNIA; DR. ALAN SPEIR, MEDICAL DIRECTOR OF CARDIAC SURGICAL SERVICES FOR INOVA HEALTH SYSTEM, AND CHAIR, WORKFORCE ON HEALTH POLICY, REFORM, AND ADVOCACY, THE SOCIETY OF THORACIC SURGEONS; DR. KEN MILLER, BOARD PRESIDENT, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS; DR. BARBARA MCANENY, CHAIR, AMA BOARD OF TRUSTEES, CEO, NEW MEXICO ONCOLOGY HEMATOLOGY CONSULTANTS LTD.; AND MR. ERIC SCHNEIDEWIND, PRESIDENT-ELECT, AARP

STATEMENT OF RICHARD UMBDENSTOCK

Mr. UMBDENSTOCK. Thank you very much. Chairman Pitts, Ranking Member Green, and distinguished members of the subcommittee, on behalf of the Nation's hospitals, thank you very much for having me here today.

Ensuring that physicians receive adequate reimbursement is important for patients and hospitals, and we support permanently replacing the Medicare sustainable growth rate, or SGR. We commend the Members of the House and Senate committees of jurisdiction, which last year unveiled legislation to fix the recurring physician payment problem by repealing the SGR formula.

The bill, however, did not include suggestions on how to cover the costs of these proposals. The AHA cannot support any proposal to fix the physician payment problem at the expense of funding for services provided by other caregivers. Offsets should not come from other providers, including hospitals, who are themselves working to provide high quality, innovative, and efficient care to beneficiaries, but are already being paid less than the cost of providing these services. Congress needs to move away from this practice.

Market forces and significant reforms in both the public and private sectors are actively reshaping America's healthcare delivery system. In 2013, hospitals employed about a third of the Nation's physicians, and this number is growing rapidly. To reduce hospital payments to prevent physician cuts is therefore counterproductive and would adversely impact the very physicians Congress is trying to help.

Hospitals' ability to maintain the access to care their patients and communities expect is further threatened by repeated ratcheting down of payments for Medicare and Medicaid hospital services to pay for other priorities.

Recognizing that the AHA cannot simply oppose hospital payment cuts without supporting other solutions, we would like to highlight policy changes where Congress could both positively impact Medicare's finances and pay for a permanent SGR fix. Specifically, we recommend taking steps to promote and reward accountability and to use limited healthcare dollars wisely.

Our recommendations are drawn from an AHA report entitled "Ensuring a Healthier Tomorrow: Actions to Strengthen Our Healthcare System and Our Nation's Finances," which is appended to my written statement. Our recommendations are similar to ideas that have received bipartisan support from a number of commissions, lawmakers, and the administration, and would not only generate savings, but also put the Medicare program on firmer financial footing for years to come.

First, modernize Medicare by combining Parts A and B with a unified deductible and coinsurance. Enrollees have conflicting incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing, because the program does not cap these expenses. This proposal would replace the current complicated mix of cost-sharing provisions with a single combined annual deductible covering all services in Parts A and B; a uniform coinsurance rate for amounts above that deductible, including the inpatient expenses; and an annual cap on each enrollee's total cost-sharing liabilities.

The administration also has proposed increased beneficiary cost sharing, such as increased Part B deductibles for new Medicare beneficiaries. The AHA agrees with the administration's position that Medicare cost sharing, quote, "helps to share responsibility for payment of Medicare services between Medicare beneficiaries," and that increased cost sharing will serve to, quote, "strengthen program financing and encourage beneficiaries to seek high-value healthcare services."

Second, make modifications to first-dollar Medigap coverage. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare utilization, costs, and Part B premiums. There are various proposals for improving incentives under Medigap. Specifics on the structure of first-dollar Medigap changes can be discussed and determined by the Congress, and the AHA is open to the administration's and CBO's proposals.

Third, increase income-related premiums under Medicare. The administration in its 2014 budget proposed doing this based on Medicare beneficiary income, and this is another approach the AHA believes Congress should explore.

And, fourth, reform the medical liability system. Hospitals and physicians continue to face skyrocketing costs for professional liability insurance.

In conclusion, there are many actions providers need to pursue, and we are working on those in areas of our control. For example, seeking to eliminate preventable infections and complications, as well as eliminating nonvalue-added treatments. And we are making real progress. Study after study confirms that hospitals are improving the quality and equity of care they deliver. Just last week the CDC announced that hospitals reduced central line associated bloodstream infections and surgical site infections by 46 percent and 19 percent, respectively, between 2008 and 2013.

The AHA's Health Research and Educational Trust directed a national project to reduce central line infections and is currently administering a program and fellowship to prevent catheter-associated urinary tract infections, as well as directing the Nation's largest hospital engagement network.

All of this shows that real improvements in health and health care, not arbitrary cuts to provider payments, have the ability to put our country on a more sustainable fiscal path, and they have received bipartisan support.

We look forward to working with the committee to solve the Medicare SGR problem. Thank you very much.

Mr. PITTS. The chair thanks the gentleman for that very constructive testimony.

[The prepared statement of Mr. Umbdenstock follows:]

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(202) 638-1100 Phone
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Statement

of the

American Hospital Association

before the

Health Subcommittee

of the

Energy and Commerce Committee

of the

U.S. House of Representatives

"A Permanent Solution to the SGR: The Time Is Now"

January 22, 2015

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, thank you for the opportunity to testify today and provide the hospital perspective on ways to pay for fixing the deeply flawed Medicare physician payment formula.

Ensuring that physicians receive adequate reimbursement for care provided is important for patients and hospitals, and we support permanently replacing the Medicare sustainable growth rate (SGR) for physician payment. We commend the members of the House and Senate committees of jurisdiction that last year unveiled legislation to fix the recurring physician payment problem by repealing the SGR formula. The bipartisan, bicameral SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015) would provide physicians a 0.5 percent payment update for five years, while encouraging physicians to transition away from fee-for-service to new payment and delivery system models based on value. This thoughtful legislation would also: consolidate the current-law physician quality reporting system, electronic health record and value-based modifier programs into one; incentivize physician participation in alternative payment models; incentivize care coordination efforts for patients with chronic care needs; and expand the use of Medicare data for transparency and quality improvement. The bill,

however, did not include suggestions regarding how to cover the cost of these proposals. The AHA cannot support any proposal to fix the physician payment problem at the expense of funding for services provided by other caregivers.

Congress needs to move away from cutting funding for services provided by other caregivers to pay for the physician fix. Offsets should not come from other health care providers, including hospitals, who are themselves working to provide high-quality, innovative and efficient care to beneficiaries in their communities and are being paid less than the cost of providing services to Medicare beneficiaries. For example, in fiscal year (FY) 2015, the Medicare Payment Advisory Commission (MedPAC) projects that the average hospital will have an overall Medicare margin of negative 9.0 percent.

Today, market forces and significant reforms in both the public and private sectors are actively reshaping America's health care delivery system. As hospitals are adapting to the changing health care landscape, they are increasingly partnering and aligning with clinicians to help achieve the Triple Aim of enhancing the patient experience, improving the health of populations and reducing the per-capita cost of health care. In 2013, hospitals employed about a third of the nation's physicians – more than 107,000 full-time doctors and dentists, as well as more than 105,000 full-time medical and dental interns and residents – and this number is growing rapidly. To reduce hospital payments to prevent physician cuts is, therefore, counterproductive and would adversely impact the very physicians Congress is trying to help. When there is greater physician-hospital alignment, providers are able to more aggressively redesign the way health services are delivered to achieve efficient and high-quality patient outcomes.

Yet hospitals' ability to maintain the kind of access to care their patients and communities expect is further threatened by repeated ratcheting down of payments for Medicare and Medicaid hospital services to pay for other priorities. Hospitals have faced more than $121 billion in cuts since 2010 alone. Additional cuts to Medicare and Medicaid funding for hospital services would mean: longer wait times for care; fewer doctors, nurses and other caregivers; and less patient access to the latest treatments and technology.

Recognizing that the AHA cannot simply oppose hospital cuts without supporting other solutions, we would like to highlight policy changes to Medicare where Congress could both have an impact on Medicare's finances and pay for a permanent Medicare physician payment fix. Our recommendations are similar to ideas that have received bipartisan support from a number of commissions, lawmakers and the administration. The year 2015 marks Medicare's 50th anniversary. It is time to make significant, structural reforms to this crucial benefit to ensure its sustainability for all seniors for the next 50 years, and beyond.

ENSURING A HEALTHIER TOMORROW

While the rate of health care spending is at an all-time low, changing demographics, the aging of the baby boom generation, the growth in chronic illness, advances in medical technology and other factors will challenge the ability to achieve a sustainable level of health care spending – especially for Medicare and Medicaid.

While traditionally the federal government has turned to cutting Medicare and Medicaid spending, almost exclusively through provider payment reductions, this will not put us on a sustainable path for the future. Numerous studies have found – and the flawed physician SGR confirms – that reducing provider payment rates does not result in reduced Medicare spending on services. Rather, we need targeted reforms for our health care system. Every stakeholder – providers, the government, insurers, employers and individuals – bears some responsibility and everyone must contribute to the solution.

The AHA recommends taking steps to promote and reward accountability and use limited health care dollars wisely. Our recommendations are laid out in a 2012 report, "Ensuring a Healthier Tomorrow: Actions to Strengthen Our Health Care System and Our Nation's Finances" (a copy of the report is attached).

These recommendations are not exhaustive, but a starting point of initiatives stakeholders can take together. There are many actions providers need to pursue, and hospitals are working on those areas within our span of control – for example, seeking to eliminate preventable infections and complications, as well as eliminating non-value-added treatments. And we are making real progress. Study after study confirms that hospitals are improving the quality and equity of care they deliver and are improving in their efforts to keep patients safe. Just last week, the Centers for Disease Control and Prevention announced that hospitals reduced central-line associated blood stream infections (CLABSI) and surgical site infections by 46 percent and 19 percent, respectively, between 2008 and 2013. Among other improvements, hospitals reduced *C. difficile* infections by 10 percent and methicillin-resistant *staphylococcus aureus* infections by 8 percent between 2011 and 2013.

The AHA's Health Research & Educational Trust affiliate directed a national project to reduce CLABSIs through the Comprehensive Unit-based Safety Program (CUSP) and is currently administering a CUSP program and fellowship to prevent catheter-associated urinary tract infections, as well as directing the largest of the nation's Hospital Engagement Networks. Similarly, provider-led initiatives like our Physician Leadership Forum's Appropriate Use of Medical Resources series and the ABIM Foundation's Choosing Wisely campaign are working to better educate providers and consumers on appropriate treatment selection. Efforts like these are having a dramatic impact on health care quality and cost. In fact, the growth of health care spending has fallen to the lowest rate since the federal government began tracking it half a century ago.

Below are several actions Congress could take that would not only generate savings, but also put the Medicare program on firmer financial footing for years to come.

Modernize Medicare by Combining Parts A and B with a Unified Deductible and Co-insurance. In traditional Medicare, beneficiaries' hospital and acute care coverage (Part A) are separate, and have a separate cost-sharing structure, from physician and outpatient services (Part B). For example, enrollees who are hospitalized must pay a Part A deductible ($1,260 in 2015) for each "spell" of illness for which they are hospitalized; in addition, they are subject to daily copayments for extended stays in the hospital and for skilled nursing care. Meanwhile, the

annual deductible for outpatient services is covered under Medicare's Part B ($147 in 2015). Beyond that deductible, enrollees generally pay 20 percent of allowable costs for most Part B services. At the same time, certain services that are covered by Medicare, such as home health visits and laboratory tests, require no cost sharing. As a result of those variations, enrollees have conflicting incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing because the program does not cap those expenses.

This proposal, as described by the Congressional Budget Office (CBO), would replace the current complicated mix of cost-sharing provisions with: first, a single combined annual deductible covering all services in Parts A and B of Medicare; second, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses); and, third, an annual cap on each enrollee's total cost-sharing liabilities. Under this option, CBO estimated the combined deductible would be $550, and the cap on total cost sharing would be $5,500.

Modernizing Medicare in this way would provide greater protection against catastrophic costs while reducing Medicare's coverage of more predictable expenses. Capping enrollees' out-of-pocket expenses would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack some supplemental (Medigap) coverage for their cost sharing. It also would increase incentives for enrollees to use medical services prudently. Deductibles and coinsurance rates expose beneficiaries to the financial consequences of decisions about health care treatments and are aimed at ensuring that services are used only when an enrollee's benefits exceed those costs. The uniform coinsurance rate across services would also encourage enrollees to compare the costs of different treatments in a more consistent way. In addition, the reductions in costs under this option for Medicare's Part B program would translate into lower premiums for all enrollees. Under this option federal outlays would be reduced by $52 billion over 10 years, CBO estimates.

Of course, any changes to Medicare beneficiaries' cost-sharing must account for income differences and be phased in to limit the impact on vulnerable populations.

The administration, in its annual budget, has also proposed increased beneficiary cost sharing, such as increased Part B deductibles for new Medicare beneficiaries. The AHA agrees with the administration's position in the budget that Medicare cost sharing "helps to share responsibility for payment of Medicare services between Medicare beneficiaries," and that increased cost sharing will serve "to strengthen program financing and encourage beneficiaries to seek high-value health care services …." Ultimately, specifics on the structure of cost-sharing changes can be deliberated, and the AHA is open to the administration's proposals; but it is important to note the program financing and shared responsibility for value that is discussed in the president's budget.

Modifications to First-dollar Medigap Coverage. About 25 percent of enrollees in fee-for-service Medicare purchase Medigap policies, and about 40 percent have retiree coverage through a former employer. By reducing or eliminating enrollees' cost-sharing obligations, those policies can, at times, mute the incentives for prudent use of medical care that cost sharing is designed to generate. The administration agrees with this dynamic – the president's 2014 budget stated:

"Medicare requires cost-sharing for various services, but Medigap policies sold by private insurance companies provide beneficiaries with additional coverage for these out-of-pocket expenses. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare costs and Part B premiums."

There are various proposals for improving incentives under Medigap. One suggestion from CBO would bar those Medigap policies from paying any of the first $550 of an enrollee's cost-sharing obligations and would limit their coverage to 50 percent of the next $4,950 of an enrollee's cost sharing (Medigap policies would cover all further cost sharing, so policyholders would not pay more than $3,025). Under this option, federal outlays would be reduced by $58 billion over 10 years, CBO estimates.

The president's proposal is structured differently, but addresses the same Medigap dynamics. The president's plan "would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, effective in 2017. Other Medigap plans that meet minimum cost-sharing requirements would be exempt from the surcharge. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium." Specifics on the structure of first-dollar Medigap changes can be discussed and determined by the Congress, and the AHA is open to the administration's and CBO's proposals.

Increasing Income-related Premiums under Medicare. All enrollees in Part B or Part D of Medicare are charged basic premiums for that coverage. Those premiums are currently $104.90 per month for Part B and an average of $31.17 per month for Part D. When the Part B program began, in 1966, the basic premium was intended to cover 50 percent of Part B costs per enrollee over age 65.

Enrollees in Parts B and D who have relatively high income pay a higher premium known as the income-related premium (IRP). The amount of the IRP depends on an enrollee's modified adjusted gross income, or MAGI (the total of adjusted gross income and tax-exempt interest). The AHA supports proposals that contemplate changes to premiums to ensure the long-term health of the Medicare program, and we believe this is apropos of this discussion to consider this option to pay for fixing the physician payment issue because significant cuts to Medicare physician payments under current law represent a significant challenge to the health of Medicare. CBO has published an analysis on raising beneficiary premiums from paying for 25 percent of Part B costs (a change made in 1997) to 35 percent. The administration in its 2014 budget proposed doing this based on Medicare beneficiary income, and this is another approach the AHA believes Congress should explore. This proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those beneficiaries who can most afford them. Under this option, federal outlays would be reduced by $52 billion over 10 years, the Office of Management and Budget estimates.

Some of our members have discussed the concept of raising the Medicare eligibility age. Such an increase would be similar to increases currently scheduled under the Social Security program,

and account for increases in life expectancy. However, some policymakers have raised objections to this approach. In an effort to promote bipartisan structural reforms to the Medicare program, we are not recommending Congress incorporate such a change in the SGR deliberations. However, we encourage Congress to continue to discuss the eligibility age as people live longer and healthier lives.

Reform the Medical Liability System. Hospitals and physicians continue to face skyrocketing costs for professional liability insurance. This is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. This also often leads clinicians to practice "defensive medicine" – providing extra, often unnecessary, care to minimize the risk of lawsuits. Steps the government could take include: establishing "safe harbor" protections for providers who follow evidence-based clinical practice guidelines; capping non-economic damages; allowing courts to limit lawyers' contingency fees; and providing prompt compensation to injured patients based on an agreed-upon payment schedule. Under these options, federal outlays would be reduced by $57 billion over 10 years, CBO estimates.

Simplify Administrative and Regulatory Processes. Providers face duplicative regulations and high compliance burdens, as well as varying claims-processing and record-keeping requirements, imposed by the array of public and private insurance plans. Care can be more affordable if health care professionals spend more time at the bedside and less time on paperwork. Insurers and employers also want to reduce administrative costs. The Center for American Progress estimated that administrative costs consume 14 percent of all health care expenditures and that at least half of this spending is wasteful. Its analysis found that reducing the administrative complexity of health care could save $40 billion annually. Additional cost savings could be achieved through regulatory relief, such as limiting and better coordinating the flood of new and often overlapping auditing programs that are burdening providers with duplicative audits, unmanageable medical record requests and inappropriate payment denials.

No one questions the need for auditors to identify fraud or correct billing mistakes; however, the multiplicity of federal, state and private payer programs are resulting in unnecessary costs and burdens. Similarly, the many credentialing and quality improvement initiatives established by regulators, private accreditors and payers have conflicting and overlapping requirements that make care delivery more expensive. CBO has not scored this proposal.

The stakes are high, and the time to act is now. These actions would help to dramatically bend the cost curve, saving billions of dollars for taxpayers.

CUTS TO HOSPITAL PAYMENTS NOT THE ANSWER

Funding for hospital services provided to Medicare beneficiaries continues to fall below the actual cost of providing care. Recognizing this, last week, MedPAC recommended increasing hospital inpatient and outpatient Medicare prospective payment system (PPS) payments in FY and calendar year (CY) 2016, respectively. These are the same recommendations the commission

approved for FY 2015. Specifically, the commission recommended increasing payment rates for the acute-care hospital inpatient and outpatient PPSs by 3.25 percent.

In FY 2015, MedPAC projects that the average hospital will have an overall Medicare margin of negative 9.0 percent. Hospitals continue to face ongoing cuts mandated by Congress, including sequestration, the documentation and coding cuts set forth in the American Taxpayer Relief Act (ATRA) and additional penalties associated with quality reporting and compliance with meaningful use requirements. In total, hospitals have faced more than $121 billion in cuts since 2010.

Now is not the time to further cut payments to hospitals. Below we outline several proposals that, if implemented, would have a devastating effect on hospitals' ability to continue delivering the high-quality, accessible care upon which their communities depend. We urge Congress to reject these proposals as it considers ways to pay for replacing the SGR formula.

Implementation of Site-neutral Payment Policies. Some in Congress have suggested adopting an ill-advised proposal that would cap "total" payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. MedPAC had estimated its policy would reduce Medicare spending by $900 million per year and $9 billion over 10 years by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

The AHA strongly opposes such legislation because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting.
- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

In addition, some in Congress have proposed capping total payment for certain HOPD services at the physician rate. MedPAC estimates that this would cut hospital outpatient payments by 2.7 percent, or $1.2 billion, in one year. The services in these 66 ambulatory payment classifications (APCs) are outpatient services that are integral to hospitals' service mission. However, MedPAC identified them as candidates for site-neutral cuts because a MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices. The policy would result in steep cuts. For instance, using data reflecting 2013 APC packaging policies, the hospital's payment for a level II echocardiogram without contrast (APC 0269) would drop from $390.49, the average amount paid in 2013 under the outpatient PPS, to $125.91 – a 68 percent reduction.

However, in recent years, CMS has been shifting the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles. As this shift

occurs, the package of services paid under the OPPS will become less comparable to those paid under the PFS, meaning the implementation of site-neutral payment policies will more likely result in unfair and inaccurate payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources – site-neutral payment policies will hamper this innovation. Steep payment cuts could have unintended consequences for patient access to care and hospitals' ability to continue to provide emergency standby services.

Additionally, MedPAC proposed an alternate site-neutral proposal that would base payments for HOPD services on the rates Medicare pays for services in ambulatory surgical centers (ASCs). The impact of this approach also would be significant; currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. This policy would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient payment by $590 million per year or a 1.7 percent decrease.

The AHA strongly opposes these cuts. Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs and offering many other services that promote the health and well-being of the community. In addition, hospitals provide emergency standby services such as:

- 24/7 Access to Care: Providing health care services, including specialized resources, 24 hours a day, seven days a week, 365 days a year.
- The Safety Net: Caring for all patients who seek emergency care regardless of ability to pay.
- Disaster Readiness and Response: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

As a part of this 24/7, safety-net and readiness, hospitals must have surgical capabilities for extremely complex patient cases, and do not enjoy the ASC capability to only prepare for the least complex outpatient cases. This high level of hospital capability must be accounted for in reimbursement.

Despite its importance, hospitals' standby role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, the standby role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider. Indeed, hospitals today face challenges in maintaining this standby role, such as staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers and the loss of patients to other settings that do not have the added costs of fulfilling the standby role. In addition, some physicians and ASCs do not serve Medicaid and charity care patients. By contrast, hospitals provided $46 billion of uncompensated care in 2012.

The critical roles that hospitals play, while often taken for granted, represent essential components of our nation's health and public safety infrastructure. It is critical that Congress consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services.

Reductions to Assistance to Low-income Beneficiaries. The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through the inpatient hospital deductible of more than $1,200 and through the outpatient hospital coinsurance of 20 percent. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as "bad debt"). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes.

The Middle Class Tax Relief and Job Creation Act of 2012 reduced these payments for PPS hospitals from 70 percent to 65 percent beginning in FY 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare paid 88 percent of allowable bad debt in FY 2013, 76 percent in FY 2014, and will pay 65 percent in 2015 and beyond.

The AHA urges Congress to reject any cuts to hospital payments for assistance in covering the debts of low-income Medicare beneficiaries. The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. Reductions exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries, such as safety-net hospitals and rural hospitals: it leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries; and it puts rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses. Rural hospitals have Medicare bad debt levels that are, on average, 50 percent higher than urban hospitals. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is inappropriate.

Medicaid frequently underpays beneficiaries' Medicare cost-sharing obligations, leading to high levels of dual-eligible beneficiary debt. Dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 59 percent of hospitals' Medicare bad debt.

Under Medicare's statutory reasonable cost principles, costs of care that are attributable to Medicare beneficiaries cannot be shifted to non-Medicare patients, and vice versa. Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of that Medicare debt directly from CMS.

Reductions to Graduate Medical Education (GME). Some policymakers are advocating a significant reduction in Medicare GME payments to teaching hospitals. The president's FY 2015 budget called for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately $14.6 billion over 10 years. The Simpson-Bowles deficit commission

recommended reducing the IME adjustment by 60 percent and limiting hospitals' direct GME (DGME) payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated $60 billion through 2020.

In July, an Institute of Medicine (IOM) committee recommended phasing out Medicare's current, separate IME and DGME payments to hospitals and replacing them with one geographically adjusted national per resident amount, paid to GME training program sponsors. If implemented, the recommendations would uncouple Medicare GME funding from patient care provided to Medicare beneficiaries, allowing current hospital GME funding to go to other entities that do not treat Medicare patients and to the creation of additional government bureaucracies. According to the IOM committee's own projections, in year five of a 10-year phase out of Medicare GME funding, teaching hospitals would effectively experience a 35 percent cut in payment for GME. The committee recommends the termination of Medicare support at the end of 10 years with no new funding source – instead, simply an assessment of the ongoing need for Medicare funding. Finally, the recommendations do not adequately address the current limits on the number of Medicare-funded residency training slots when our nation is already facing a critical shortage of physicians. The report also ignores how hospitals are already addressing the changing health care landscape by: providing training in outpatient settings such as community clinics; giving a common infrastructure to support all residents; and recognizing that some specialties, like neurosurgery, require training only in an inpatient environment.

The AHA urges Congress to reject reductions in Medicare funding for IME and DGME. The nation is already facing a critical shortage of physicians, and cuts to IME/DGME would further exacerbate the problem. Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025; the expansion of health care coverage would increase overall demand for physicians and increase the projected physician shortfall by up to 31,000 physicians. Physician shortages would hamper national efforts to improve access to care and may result in longer wait times for patients.

Cuts to GME funding would also jeopardize the ability of teaching hospitals to train the next generation of physicians. They would force teaching hospitals to eliminate staff, close training programs and eliminate services operating at a loss. In February 2011, the Association of American Medical Colleges estimated the impact of federal IME cuts and found that a 60 percent reduction in IME payments could mean a loss of 72,600 jobs, $653 million in state and local tax revenue and $10.9 billion to the U.S. economy.

Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. We urge Congress to eliminate the 18-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots) as included in the Resident Physician Shortage Reduction Act of 2013, introduced by Rep. Joseph Crowley (D-NY).

Changes to the CAH Program. Approximately 51 million Americans live in rural areas and depend upon the hospital as an important, and often the only, source of care in their community. Remote geographic location, small size and limited workforce, along with physician shortages and often constrained financial resources, pose a unique set of challenges for rural hospitals. Compounding these challenges, rural hospitals' patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts.

Medicare and other federal programs need to account for the special circumstances of rural communities. This includes securing the future of existing special rural payment programs – including the critical access hospital, sole community hospital, Medicare-dependent hospital and rural referral center programs.

Some lawmakers, and the administration, have proposed changes to the CAH program that would have a detrimental impact on health care in many vulnerable rural communities. The AHA continues to advocate that Congress maintain current policies which provide vital funding for rural and small hospitals. This includes:

- ensuring CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- ensuring rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- providing CAHs with bed-size flexibility;
- reinstating CAH necessary provider status; and
- removing unreasonable restrictions on CAHs' ability to rebuild.

In addition to their vulnerability to payment cuts and harmful changes to vital rural programs, small and rural hospitals are disproportionately affected by burdensome federal regulatory policies, threatening their ability to provide care to the patients and communities they serve. These regulatory burdens include the 96-hour rule, the outpatient therapeutic services direct supervision policy and the electronic health records and meaningful use regulations. CMS should better account for the unique circumstances of rural providers in the rulemaking process.

Changes to Post-acute Care Payment. In recent years, post-acute care providers have faced great scrutiny from Congress. More recently, the Bipartisan Budget Act of December 2013 (BiBA) implemented a site-neutral payment policy for LTCHs, which will reduce payments for one out of two long-term care hospital (LTCH) cases – a cut of $3 billion. And the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) sets in motion for each of the post-acute settings a more consistent reporting infrastructure and the development of a consolidated post-acute payment system prototype.

In addition, the president's FY 2015 budget would lower inpatient rehabilitation facility (IRF) reimbursement for selected patients to a skilled nursing facility (SNF) level payment, and raise the current IRF "60% Rule" threshold. Similar proposals are anticipated in the president's FY 2016 budget. These proposals overlook clear distinctions between SNF and IRF patients and services, as mandated and documented by CMS. As a result of tougher Medicare standards, IRF case mix has increased and the number of IRF patients has dropped by 140,000 cases annually since 2004. IRFs help beneficiaries regain physical and cognitive function after major health

events such as strokes, brain injuries and spinal cord injuries. And they provide further value to the overall system of care with their low readmissions rate.

Independent Payment Advisory Board (IPAB). Created by the Affordable Care Act (ACA), IPAB is a commission appointed by the president and empowered to establish reimbursement rates for the Medicare program. Although hospitals will not be subject to IPAB decisions until 2020, we are concerned that removing elected officials from the decision-making process could result in even deeper cuts to the Medicare program in the future. The AHA supports the repeal of IPAB, because its existence permanently removes Congress from the decision-making process, and threatens the important dialogue between hospitals and their elected officials about how hospitals can continue to provide the highest quality care to their patients and communities.

Changes to the 340B Drug Pricing Program. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to eligible public and non-profit health care facilities that care for large numbers of uninsured and low-income people. The program enables eligible entities, including certain hospitals, to stretch scarce federal resources to expand and improve access to comprehensive health care services to more patients in the communities they serve.

Since the program was established in 1990, Congress has acted several times to expand it. Currently, community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals, sole community hospitals, rural referral centers and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations are eligible to participate in the program. These entities must meet a variety of requirements to participate in the program, including: yearly recertification; audits from both the Health Resources and Services Administration (HRSA), which oversees the program, and drug manufacturers; and maintaining auditable inventories of all 340B and non-340B prescription drugs.

Hospitals that participate in the 340B program use the savings to provide enhanced services to their patients, including, but not limited to: funding other medical services, such as obstetrics, diabetes education, oncology services and other ambulatory services; providing financial assistance to patients unable to afford their prescriptions; providing clinical pharmacy services, such as disease management programs or medication therapy management; establishing additional clinics; creating new community outreach programs; and offering free vaccines.

The AHA opposes any efforts to scale back or reduce the benefits of the 340B program. The 340B program has a proven track record of decreasing government spending and helping safety-net providers stretch limited resources to increase access to care for the vulnerable patients and communities they serve. In addition, HRSA has undertaken many efforts to exert more oversight of the program. The AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers and encourages HRSA to develop a process to help financially-distressed providers meet new program integrity provisions.

Restrictions on Medicaid Provider Assessments. The Medicaid provider assessments program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their

portion of the joint federal/state program. Some policymakers have called for restricting states' ability to use assessments as a financing tool. The president's FY 2013 budget had proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015. The administration estimated this would save $21.8 billion over 10 years. The House approved its FY 2013 budget reconciliation package with cuts to Medicaid provider assessments of $11.2 billion over 10 years. The Simpson-Bowles deficit commission also recommended restricting, and eventually eliminating, states' ability to use assessments on health care providers to finance a portion of their Medicaid spending. This proposal to eventually eliminate provider assessments would result in estimated reductions of $44 billion in the Medicaid program by 2020.

The AHA urges Congress to reject options that restrict states' ability to partially fund Medicaid programs using provider assessments. Restrictions in the use of provider assessments are just another name for Medicaid cuts. Further cuts to funding for hospital services would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program. Hospitals already experience payment shortfalls when treating Medicaid patients. Medicaid, on average, covers only 89 cents of every dollar spent treating Medicaid patients. Changes to the provider assessment program would further exacerbate this problem. Currently, 67 million low-income Americans rely on the Medicaid program to provide access to health care. With implementation of the ACA, as many as 13 million more people may be enrolled in Medicaid (based on April 2014 CBO estimates). Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.

CONCLUSION

The AHA and the hospital field appreciate your consideration of these issues. Real improvements in health and health care – as opposed to arbitrary cuts to provider payment – have the ability to put our country on a more sustainable fiscal path and have received bipartisan support. But reining in health care spending is only one part of the solution to our nation's fiscal crisis. And, hospitals are just one component of the health care system. Together, we need to create solutions that allow individuals to access the care they need, when and where they need it and have it delivered in the safest, most cost-effective manner. By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.

[The attachment to Mr. Umbdenstock's statement has been retained in committee files and can be found at: *http://docs.house.gov/meetings/if/if14/20150122/102827/hhrg-114-if14-wstate-umbdenstockr-20150122.pdf*.]

Mr. PITTS. Dr. O'Shea, you are recognized for 5 minutes.

STATEMENT OF GERALDINE O'SHEA

Dr. O'SHEA. Chairman Pitts and Ranking Member Green, members of the subcommittee, on behalf of the American Osteopathic Association, thank you for the opportunity to testify today on the importance of permanently reforming the Medicare physician payment system.

My name is Geraldine O'Shea. I am a DO, I am a board certified osteopathic internist from Jackson, California. I have been practicing osteopathic medicine for 22 years. Osteopathic physicians, like MDs, are fully licensed to prescribe medicine and practice in all specialty areas, including surgery. DOs are trained to consider the health of the whole person and use their hands to help diagnose and treat their patients. DOs take care of people, not problems, and utilize a mind, body and spirit, patient-centered approach to healing itself. DOs use this approach in addition to all other modalities of modern medicine.

Over 60 percent of practicing DOs specialize in primary care fields. The profession also has a longstanding history of training physicians who practice in rural and other underserved areas. I am currently the medical director of Foothills Women's Medical Center in Jackson, California. My practice is comprised of women's health and primary care and also hospital care, and I deliver it each day, and I have the opportunity to see and treat my patients. I also serve on the Board of Trustees for the American Osteopathic Association, which represents 110,000 osteopathic physicians and osteopathic medical students, who are training in 30 colleges of osteopathic medicine in 42 locations across our Nation.

Today I will share with you my personal experience of the detrimental impact the current Medicare physician payment system has on all physicians and how it is a barrier to high-quality care for our Nation's seniors. My charge here is not only to represent osteopathic physicians and medical students and our medical M.D. Colleagues, but really to advocate for the patients that we serve.

Payment reform should no longer be an if, but must be a when, and the time is now. The current system is stifling innovation and preventing a move to a system focused on quality of care instead of volume. It is also stifling a move to delivery models focused on care coordination and a systems approach.

As a DO, this fragmentation does not align with my training and the philosophy behind osteopathic medicine. It is time we looked past short-term solutions. We must instead consider the Medicare system as a whole, physicians and other providers, and most importantly our seniors. The impact of inaction today or continuation of only treating the short-term problem will have negative repercussions for the health of Medicare, and we must keep this in mind throughout today's discussions.

The osteopathic profession continues to fully support the bicameral, bipartisan policy framework that was developed last year

by all three committees of relevant jurisdiction in Congress, and we thank you all here too. We greatly appreciated that the committees incorporated input from the physician communities at every step of the way and gained overwhelming support of the house of medicine, and that is not an easy task.

Quality of care will ultimately improve when payment incentives increase and are aligned with healthcare quality. The proposal would stabilize physician payments while transitioning into a system that promotes the delivery of high-quality patient care. The new system includes strong recognition of the importance of primary care as supported by the patient-centered medical home. The AOA was one of the four organizations which developed the principles of the medical home.

The proposal also works to align the current disjointed quality reporting programs to ease the administrative burdens placed upon physicians. This means we can spend less time with paperwork and more time with our patients, where we are needed most.

There have been various proposals advanced and discussed over the years by lawmakers and advocates on how to specifically pay for or even not pay for a permanent fix to the SGR. However, we need to consider the whole system, just as the osteopathic physician considers the whole person in determining how an illness or issue might be impacting a patient.

Recent congressional discussions on other healthcare priorities have included strong consideration of unpaid legislative solutions, and these considerations should also be extended to payment reform. We must recognize there cannot be significant legislative action on other important healthcare priorities until the physician payment issue is permanently resolved. It is not for us as physicians to be prescriptive in which specific approach Congress should take in offsetting a permanent solution to a reformed Medicare physician payment system.

Whether targeted, unpaid, OCO, or a combination of these offset approaches, we urge Congress to consider the potential impact to the entire healthcare system, particularly on our patients. Jeopardizing patient access to care within the Medicare program cannot be an option. The AOA advocates for the patients we serve, including enhancing their access to care, to protecting the patient-physician relationship, because we believe this is vital to the delivery of quality health care.

As leaders of Congress, we do implore you to take action now, before March 31, to fix the physician payment system permanently, protect seniors, and strengthen the Medicare program.

I thank you for your time today. I am hopeful on behalf of my physician colleagues and patients that this Congress will get this issue resolved permanently. And I thank you very much.

Mr. PITTS. We hope so. Thank you very much, Dr. O'Shea.

[The prepared statement of Dr. O'Shea follows:]

Statement of Geraldine T. O'Shea, DO

Submitted on Behalf of the American Osteopathic Association

Presented to the

House Energy & Commerce Committee

Subcommittee on Health

Hearing on "A Permanent Solution to the SGR: The Time Is Now"

January 22, 2015

Summary

Medicare physician payment reform should reflect a long-term, holistic approach, and is an opportunity to move beyond a short-term solution to a problem that directly impacts the health and well-being of our nation's most vulnerable citizens.

The Burden of SGR:

- The current Medicare physician payment system has a detrimental impact on all physicians, and is a barrier to the provision of high-quality care for our nation's seniors.
- Reforming the Medicare physician payment system before the current patch expires on March 31 should no longer be an "*if*," but must be a "*when*."
- We must consider the Medicare system as a whole – physicians, other professionals and providers, and most importantly seniors.

Reaching a Solution: The legislation agreed to by the previous Congress and the physician community would replace the current system with one that ultimately rewards physicians for providing high-quality care for the millions of seniors covered under the Medicare program.

Work Remains: Whether targeted, unpaid, OCO, or a combination of any of these offset approaches, we urge Congress to consider the potential impact to the *entire* health care system that a particular offset approach might have, creating a ripple effect beyond one portion of the system—just as the osteopathic physician considers the whole person in determining how an illness or issue might be impacting a patient. Our nation's seniors and their loved ones, and the providers who care for them must remain top of mind. Recent Congressional discussions on other health care priorities have included strong consideration of unpaid legislative solutions, and we therefore submit that these considerations should also be extended to payment reform.

Statement of Geraldine T. O'Shea, DO on Behalf of the American Osteopathic Association

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, on behalf of the American Osteopathic Association (AOA) and the more than 110,000 osteopathic physicians and osteopathic medical students we represent, thank you for the opportunity to testify today on the importance of permanently reforming the Medicare physician payment system. My name is Geraldine O'Shea, DO, and I am a board certified osteopathic internist from Jackson, California.

I have been a practicing osteopathic physician for 22 years, and have experienced dramatic changes in the practice and delivery of health care in the United States. One thing has remained the same -- the sanctity of the patient-physician relationship. As an osteopathic physician, I am trained to take a holistic approach to caring for my patients. My testimony today regarding Medicare physician payment will also reflect a long-term, holistic approach, and the opportunity to move beyond a short-term solution to a problem that directly impacts the health and well-being of our nation's most vulnerable citizens.

I am currently the medical director of Foothills Women's Medical Center in Jackson, California, in the foothills of the Sierras. My practice is comprised of women's health, primary, and hospital care delivery where each day I have the opportunity to see and treat patients. I am the current president of the American Association of Osteopathic Examiners; the board comprised of all osteopathic physicians who are members of state medical boards.

I also serve on the Board of Trustees of the AOA, a professional membership association that exists to promote public health; encourage scientific research; serve as the primary certifying body for doctors of osteopathic medicine (DOs); be the accrediting agency for osteopathic medical schools;

maintain a CMS-approved registry for quality reporting; and accredit hospitals and other health care facilities.

My charge here today is not only to represent osteopathic physicians and osteopathic medical students, and our MD colleagues, but also to advocate for the patients we have the privilege to serve as physicians in this great nation.

In my 26 years as an AOA member, I have been able to interact and work with my colleagues as the practice and business of medicine has transformed. I directly witnessed this in my previous capacity as chair of the AOA committees that oversee scientific affairs and public health, federal health programs, and women's health issues.

Today, I will share with you my personal experience of the detrimental impact the current Medicare physician payment system has on all physicians, and how it is a barrier to the provision of high-quality care for our nation's seniors.

Background on the Osteopathic Profession

Osteopathic physicians – like MDs – are fully licensed to prescribe medicine and practice in all specialty areas, including surgery. DOs are trained to consider the health of the whole person and use their hands to help diagnose and treat their patients. DOs are one of the fastest growing segments of health care professionals in the United States. Currently, more than one in four medical students in the United States are training to become osteopathic physicians. There are currently 30 colleges of osteopathic medicine accredited to deliver instruction at 42 teaching locations in 28 states.

Our academic and training model places an emphasis on preparing osteopathic medical students for careers in physician specialties such as family medicine, internal medicine, obstetrics/gynecology, general surgery, and emergency medicine. Our academic curricula, along with a community-based training model, are the primary reasons the profession has enjoyed great success in producing primary care physicians and community-based specialists.

Today, over 60 percent of practicing DOs specialize in such primary care fields as family medicine, general internal medicine, and pediatrics. The profession continues to believe that the most effective health care system is built on a strong foundation of community-based primary care.

The profession also has a long-standing history of training physicians who practice in rural and other underserved areas. Many of our colleges are located in geographic regions with acute physician shortages, such as western Washington, Arizona, and Central Appalachia where we have four colleges of osteopathic medicine. This commitment to establishing colleges and training opportunities in areas of need is key to meeting the health care needs of underserved communities.

This reflects the osteopathic medical profession's strong dedication to both primary care and rural service to meet the needs of the American public through our specialty and geographic distribution.

The Burden of SGR

As the title of the hearing denotes, the time for a permanent solution is indeed now. The osteopathic medical profession stands ready to work with Congress to achieve this goal. Repealing

the sustainable growth rate (SGR) and reforming the Medicare physician payment system before the current patch expires on March 31 should no longer be an "*if*," but must be a "*when.*"

Elderly patients for too long have been impacted by the current broken payment model. Congress has heard our calls year upon year to reform the system, but has only been successful delivering annual, or sometimes even monthly, fixes which do not address the problem. Physicians have been appreciative of Congress' work to prevent drastic cuts to our Medicare payment rates. However, preventing cuts is only one step to ensure that Medicare patients have access to physicians when and where they need us.

Physicians do not want to leave the Medicare program, but payment rates that have not kept pace with the cost to practice medicine are making it nearly impossible for many of us to continue. We do not want to leave our patients, our seniors, your constituents, with fewer options for medical care; we were trained to heal, after all.

I believe we can all agree that it is time we look past the short-term solution, and delve into the long-term solution through a holistic approach. As we look at this issue through that lens, we must consider the Medicare system as a whole – physicians, other professionals and providers, and most importantly seniors. The impact of inaction today or a continuation of only treating the short-term problem could have negative repercussions for the health of Medicare, and we must keep that in mind throughout today's discussion.

Reaching a Solution

After more than a dozen years of repeated uncertainty over looming cuts to Medicare physician payment, and seventeen costly patches that merely postponed this uncertainty only to revisit it once again, the opportunity to permanently reform the system and repeal the SGR formula once and for all is now.

We were very encouraged by the bicameral, bipartisan policy framework that was developed last year by all three committees of jurisdiction in Congress, including your own, and embraced by Republicans and Democrats alike. Your work provided a solid foundation for permanently repealing the SGR and advancing physician payment reform. We greatly appreciated that the Committees incorporated input from the physician community at every step of the way, and gained the overwhelming support of the house of medicine.

This unprecedented collaborative effort demonstrates the near-universal recognition across stakeholders of how critical it is for this problem to finally be addressed. The legislation would replace the current system with one that ultimately rewards physicians for providing high-quality care for the millions of seniors covered under the Medicare program. The current system is untenable as it drives unnecessary treatments, tests, and/or medications resulting in increased morbidity and mortality – driving up the costs of care. Quality of care will ultimately improve when payment incentives increase and are aligned with health care quality.

The AOA continues to strongly support this legislative package, as it stabilizes physician payments while transitioning from fee-for-service into a system that not only incentivizes the delivery of high-quality patient care, but also works to align the current quality reporting programs to ease the

administrative burden placed upon physicians. This means we will spend less time with paperwork and more time with our patients, where we are needed the most. This is not a short-term solution; this is a holistic approach that will benefit patients, physicians, and the Medicare program as a whole.

Work Remains

The reason we are all here today is because the work is not complete. We understand that enacting this legislation into law may cost an estimated $144 billion to offset its implementation over 10 years. We cannot forget that over the past decade Congress has already spent much more than that—over $170 billion—on short-term SGR patches. $170 billion spent and we are still in the same system with the same perverse incentives, and still jeopardizing access to care for our seniors.

There have been various proposals advanced and discussed over the years by lawmakers and advocates on how to specifically pay for, or even not pay for, a permanent fix to the SGR.

Some of these proposals would have a significant and direct impact on a particular stakeholder group. However, just as the osteopathic physician considers the whole person in determining how an illness or issue might be impacting a patient, we urge Congress to consider the potential impact to the *entire* health care system that a particular offset approach might have, creating a ripple effect beyond just the portion of the system it is initially thought to impact.

Another long-considered approach that would have minimal impact is use of the Overseas Contingency Operations (OCO) funding that remains from the war efforts abroad. From an accounting standpoint, the very framework of the SGR is viewed as a budget gimmick. By using OCO funds to offset the cost of SGR repeal, Congress would be correcting assumptions of higher

spending (OCO funds) and expected savings (SGR payment cuts to doctors) that will never take place—thereby producing a more accurate budget.

In simpler terms, the budget baseline is based upon the assumption that the OCO funds will be spent over the next several years, and the scheduled double-digit SGR payment cuts will go into effect annually – both of which are likely false. False OCO spending and false SGR savings negate one another.

As well, still others have advocated for an approach in which the cost of the legislation would not be offset. Recent Congressional discussions on other health care priorities have included strong consideration of unpaid legislative solutions, and we therefore submit that these considerations should also be extended to the SGR.

Next Steps

Ultimately, it is not for us as physicians to say which approach Congress should take in offsetting a permanent solution to a reformed Medicare physician payment system. Whether offsets are targeted, unpaid, use OCO, or are a combination of any of these approaches, we urge Congress to consider the impact it could have on all stakeholders of the health care system—our nation's seniors and their loved ones, and the providers who care for them must remain top of mind.

Further jeopardizing their access to care within the Medicare program cannot be an option – permanently reforming the physician payment system is one barrier to access that we are working to remove in this process, after all. The AOA, as a physician association, also advocates for the

patients we serve, including enhancing their access to care and protecting the sacred patient-physician relationship, which is vital to the delivery of quality health care.

While we recognize the political reality that makes these discussions on an approach to offsetting the legislation difficult, as leaders of Congress we implore you to aggressively pursue and reach agreement on a solution before time runs out. Continuing to enact yet another patch this March would be poor fiscal policy – the equivalent to only paying the monthly minimum on a credit card bill and not addressing the underlying debt.

Conclusion

On behalf of the American Osteopathic Association, the 110,000 osteopathic physicians and osteopathic medical students we serve, and all physicians who care for older Americans every day through the Medicare program, I urge Congress to continue the tremendous bipartisan spirit that has been a part of this effort to date. Together, we can approach this issue holistically and finally heal the underlying ailment.

Thank you for the opportunity to provide testimony before this Subcommittee, and for your interest in permanently resolving this issue. Osteopathic physicians and our physician colleagues across the country look to you to complete the work that has already begun, and look forward to other additional health care discussions before this Committee once this issue is resolved.

Mr. PITTS. Dr. Speir, you are recognized for 5 minutes for your opening statement.

STATEMENT OF ALAN SPEIR

Dr. SPEIR. Thank you. Good morning. Chairman Pitts, Ranking Member Green, and distinguished members of the committee, thank you for the opportunity to present testimony today on behalf of the Society of Thoracic Surgeons. My name is Alan Speir, and I am a practicing cardiothoracic surgeon and medical director of Cardiac Surgical Services just across the river in the Inova Health System. I am also chair of the Workforce on Health Policy, Reform, and Advocacy for the Society of Thoracic Surgeons, and chair of the Board of Directors for the Virginia Cardiac Surgery Quality Initiative.

Founded in 1964, the STS is an international not-for-profit organization representing more than 6,800 surgeons, researchers, and allied healthcare professionals in 90 countries who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, and other surgical procedures within the chest.

On behalf of the Society, I would like to applaud this committee for holding a hearing on Medicare physician payment reform just 11 days into this new Congress. We are grateful for your sense of urgency and are eager to work with you to ensure that permanent SGR repeal and Medicare payment reform are enacted this year.

I would also like to thank you for introducing the SGR Repeal and Medicare Provider Payment Modernization Act in the last Congress. I would implore you not to leave this major policy achievement to languish beyond the current March expiration of the current SGR patch.

I hope that my testimony today helps to demonstrate that the cost of continuing nothing will be far more devastating to Medicare patients and providers than the expense of implementing a meaningful payment reform policy.

In my written comments, I provide additional information on the STS National Cardiac Database and the Virginia Cardiac Surgery Quality Initiative, both of which provide a foundation for our remarks here today. Established in 1989, the fundamental principle underlying the STS National Database has been that surgeon engagement in the process of collecting information on every case, combined with robust risk adjustment based on pooled national data and feedback of such data to the individual practice and institution, will provide the most powerful mechanism to change and it will improve the practice of surgery for the benefit of our patients. For example, published results of patients undergoing coronary artery bypass surgery between 2000 and 2009 in institutions participating in the database realized a 24 percent reduction in mortality and a 26 percent reduction in perioperative stroke.

The VCSQI is a regional collaborative that is voluntary within the Commonwealth of Virginia, comprised of 14 cardiac surgical practices and 18 hospitals, founded in 1994 to improve the results of cardiac surgical care and to reduce cost. By creating evidence-based protocols using patients' clinical information, matched with administrative and cost data, the VCSQI demonstrated improving quality will reduce costs. For example, the VCSQI generated more

than $43 million in savings to all payers through blood product conservation efforts, and more than $20 million in savings by identifying the best treatment for cardiac surgical patients with a perioperative arrhythmia called atrial fibrillation.

The STS has long advocated that claims information is critical to the effort to provide patient outcomes and care efficiencies. We are particularly grateful that the proposed SGR legislation would have allowed qualified clinical data registries to access Medicare administrative claims data. This legislation would also have provided a pathway for the development of specially driven alternative payment models that will allow payments and providers alike to benefit from quality and efficiency improvements.

Essential to that transition is a period of predictable payment for physicians without the threat of SGR-related cuts. It is this last point, the opportunity to develop alternative payment models during a so-called period of stability, where I would like to focus my remaining comments.

Inspired by this in innovative proposal, the STS convened our thought leaders and policy and registry experts to examine the procedures most frequently performed by the STS. Together, we worked to craft team-based alternative payment models for the Heart Team and Lung Cancer Care Team in hopes that these models will provide a blueprint for other care team models in our specialty. We are confident that we can use the STS cardiac database, combined with administrative claims data and quality information from others in the care team, to promote patient-centered, team-based care that improves clinical outcomes and patient satisfaction, lowers healthcare costs, and rewards all providers by putting the patient first.

While our APM concepts are not yet finalized, I wanted to demonstrate to this committee that the physician community is ready and eager for this opportunity. Unfortunately, as we wait for payment reform to become a reality, the Centers for Medicare and Medicaid Services is implementing policy that will decimate the proposed period of stability, stifle innovation, and limit our ability to transition to new alternative payment models. Specifically, CMS proposes to convert more than 4,000 10- and 90-day global surgical CPT codes to a zero-day global by 2017 and 2018 respectively.

Currently, the cardiothoracic surgeons receive a single bundled payment from Medicare for the surgeries they perform. This payment includes preoperative consultation, the operative procedure itself, perioperative and post-operative care, and coordination of medical specialty consultations and outpatient visits.

Mr. PITTS. If you can summarize, please.

Dr. SPEIR. Thank you.

It is clear that the Medicare payment reform is fatally flawed. Furthermore, with the uncertainty of the SGR paradigm, compounded by CMS global payments issues, innovation and meaningful physician-led reform is nearly impossible.

Mr. PITTS. Thank you very much, Dr. Speir.

[The prepared statement of Dr. Speir follows:]

House Committee on Energy and Commerce

Subcommittee on Health

A Permanent Solution to the SGR: The Time is Now

January 22, 2015

Alan Speir, MD, Testimony on behalf of The Society of Thoracic Surgeons

Chairman Pitts, Ranking Member Green, and distinguished members of the Committee, thank you for the opportunity to present testimony today on behalf of The Society of Thoracic Surgeons (STS). My name is Alan Speir. I am a practicing cardiothoracic surgeon and Medical Director of Cardiac Surgical Services, Inova Health System. I am also the Chair of the Workforce on Health Policy, Reform, and Advocacy for The Society of Thoracic Surgeons and Chair of Board of Directors for the Virginia Cardiac Surgery Quality Initiative.

Founded in 1964, STS is an international, not-for-profit organization representing more than 6,800 surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best possible outcomes for surgeries of the heart, lung, and esophagus, as well as other surgical procedures within the chest.

On behalf of the Society, I would like to applaud this Committee for holding a hearing on Medicare physician payment reform just eleven days into the new Congress. With only a handful of weeks before the current SGR patch expires, we are grateful for your sense of urgency and are eager to work with you to ensure that permanent SGR repeal and Medicare payment reform are enacted this year. I also would like to thank many of the current members of this Committee for their considerable work to introduce The SGR Repeal and Medicare Provider Payment

Modernization Act in the last Congress. STS endorsed this bipartisan, bicameral agreement, which won support across the physician community. I implore you not to leave this major policy achievement to languish beyond the March expiration of the current SGR patch. I hope that my testimony today helps to demonstrate that, the cost of continuing to do nothing would be far more devastating to Medicare patients and providers than the expense of implementing meaningful payment reform policy.

The STS National Database

The STS National Database was established in 1989 as an initiative for quality assessment, improvement, and patient safety among cardiothoracic surgeons. The Database has three components—Adult Cardiac, General Thoracic, and Congenital Heart Surgery. The fundamental principle underlying the STS National Database initiative has been that surgeon engagement in the process of collecting information on every case combined with robust risk-adjustment based on pooled national data, and feedback of the risk-adjusted data provided to the individual practice and the institution, will provide the most powerful mechanism to change and improve the practice of cardiothoracic surgery for the benefit of patients. In fact, published studies indicate that the quality of care has improved as a result of research and feedback from the STS National Database.

For example, ElBardissi and colleagues studied 1,497,254 patients who underwent isolated primary Coronary Artery Bypass Graft (CABG) surgery at STS National Database participating institutions from 2000 to 2009. They found that:

- Patients received more indicated care processes in recent years, including a 7.8% increase in the use of angiotension-converting enzyme inhibitors preoperatively and a significant increase in the use of the internal thoracic artery (88% in 2000 vs. 95% in 2009).
- The observed mortality rate over this period declined from 2.4% in 2000 to 1.9% in 2009, representing a relative risk reduction of 24.4% despite the predicted mortality rates (2.3%) remaining consistent between 2000 and 2009.
- The incidence of postoperative stroke decreased significantly from 1.6% to 1.2%, representing a relative risk reduction of 26.4%.
- There was also a 9.2% relative reduction in the risk of reoperation for bleeding and a 32.9% relative risk reduction in the incidence of sternal wound infection despite the acuity of patients increasing during this period of examination.

The Database has facilitated advancements in many aspects of health care policy including public reporting of health care quality measures, facilitating medical technology approval and coverage decisions, and even saving money by helping cardiothoracic surgeons to find the most efficient and effective way to treat patients. Our ability to link clinical data with administrative data through the STS National Database has opened up important new ways to assess the effectiveness of treatment options and offered new avenues for medical research. Clinical data yield sophisticated risk-adjustment assessments, while administrative data provide information on long-term outcomes such as mortality rate, readmission diagnoses, follow-up procedures, medication use, and costs. In addition, linking clinical registries to the Social Security Death Master File (SSDMF) once allowed for the verification of "life status" of patients who otherwise would be lost for follow up after their treatment. The outcomes information

derived from these data sources helps physicians educate today's patients and families so that they can play an active and informed role in the shared decision-making process. Valid and reliable outcomes data give patients confidence in their medical interventions and demonstrate to patients and their families the durability and long-term risks and benefits of medical procedures based on real-life, quantified experience rather than abstract concepts.

Unfortunately, in November 2011, the Social Security Administration rescinded its policy of sharing state-reported death data as a part of the SSDMF so as to protect those listed in the file from identity theft. Balanced against these legitimate privacy concerns are the many advantages of linked administrative and outcomes data when placed in the right hands, with adequate protections in place. It is important to note that STS, through its contracts with the Duke Clinical Research Institute, maintains the patient identifier data separately from the actual clinical and other demographic data, and the only patient level identified information that ever leaves the database is simply that the patient has a record in the database. When combining records with outside sources, patient identification information is matched against other records, such as those in the SSDMF. The follow-up information is returned from external entities and linked back to the records in the de-identified database. The externally derived data are used to supplement the data in the individual record, but these clinical, patient-level data never leave the database except in de-identified form.

Even without this important information, we have proven that the Database can serve as the foundation for appropriate use criteria and even medical liability reform. Perhaps most importantly, we have shown that allowing surgeons to receive feedback on their performance and

compare themselves to their peers elevates the practice of cardiothoracic surgery. Other innovations pioneered using the STS National Database include:

- Public Reporting: STS launched a Public Reporting Initiative in January 2011 in collaboration with Consumer Reports. As of December 2014, 42% of Database participants voluntarily report their results for Coronary Artery Bypass Graft (CABG) and/or aortic valve replacement on the Consumer Reports or STS websites. STS is universally regarded as the medical professional society leader in these activities.
- Medical Technology Approval and Coverage Decisions: The TVT Registry™ is a benchmarking tool developed to track patient safety and real-world outcomes related to the transcatheter aortic valve replacement (TAVR) procedure. Created by STS and the American College of Cardiology, the TVT Registry is designed to monitor the safety and efficacy of this new procedure for the treatment of aortic stenosis. The TVT Registry was instrumental in facilitating the approval and coverage with evidence development of new medical technology, helping to bring this technology to the marketplace safely and efficiently.
- Comparative Effectiveness Research: The Patient Centered Outcomes Research Institute has recognized the value of "observational research" using clinical registries to fulfill its mission. Furthermore, registries such as the TVT Registry can be developed and augmented to collect real time data to measure outcomes in different patient populations in real time. We believe that comparative effectiveness research can help physicians, in collaboration with patients and families, to provide the right care at the right time, every time.

- Determining Value of Physician Services: STS has used the time data from the STS National Database as the basis for relative value recommendations to the AMA Relative Value Update Committee. Unfortunately, the use of this type of real data has been resisted by CMS with the rationale that other specialties are not able to provide comparable data. Congress should encourage CMS to use real, clinical data on procedural time and hospital lengths of stay collected via a clinical registry rather than time estimates which distort the relativity of the fee schedule.
- Appropriate Use Criteria and Medical Liability Reform: STS believes that setting standards aligned with best practices identified by specialty societies is the best way to institute meaningful medical liability reform. Quality measurement and data on clinical risk can be used to reduce lawsuits and the cost of liability insurance, and to restore balance to the justice system.

One of the most successful examples of innovation founded in the STS National Database is the Virginia Cardiac Surgery Quality Initiative (VCSQI). The VCSQI, a voluntary regional collaborative in the Commonwealth of Virginia comprised of 12 cardiac surgical practices in 18 hospitals, was founded in 1994. The purpose of this organization has been to improve the results of cardiac surgical care and reduce costs by sharing clinical data, outcomes analysis, and process improvement. VCSQI helps implement protocols to reduce post-operative complications, was involved in the adoption of quality measures in cardiac surgery for the National Quality Forum, and has formulated policies on pay for performance programs. All of the VCSQI programs participate in the STS National Database and uniformly follow the definitions and measures in this landmark clinical registry. This Initiative has constructed a

database of over 90,000 patients who have undergone cardiac surgery, matching the patients' STS clinical record with outcomes information and discharge financial data for each episode of care.

VCSQI has attempted to test a global pricing model and has implemented a pay-for-performance program whereby physicians and hospitals are aligned with common objectives. Although this collaborative approach is a work in progress, collaborators point out that a road map of short-term next steps is needed to create an adaptive payment system tied to the national agenda for reforming the delivery system. Using evidence-based protocols, VCSQI has demonstrated that improving quality will reduce cost. For example, the VCSQI generated more than $43 million dollars in savings through blood product conservation efforts and more than $20 million dollars in savings by providing the best treatment to patients with atrial fibrillation.

Medicare Physician Payment Reform

STS has been a strong proponent of leveraging the unique power of clinical registries, combined with administrative claims and patient outcomes data, to improve quality and efficiency in the healthcare system. In fact, we firmly believe that, without a national infrastructure for collecting, aggregating, and evaluating clinical information against valid, risk-adjusted quality measures, any effort towards true payment reform would be difficult if not impossible. Through its focus on clinical registries, we believe that the policy outlined in the SGR legislation introduced in the last Congress would make incredible strides towards developing such an infrastructure. The STS recognizes that claims information is critical to the effort to improve patient outcomes and care efficiency, and we were particularly grateful that the

proposed SGR legislation would have allowed qualified clinical data registries to access Medicare administrative claims data. We hope that similar access to the SSDMF can also be restored. I would also like to underscore STS's support of the following provisions included in that legislation:

- A threshold model of physician performance measurement under the Merit-based Incentive Payment System that allows all providers to be rewarded for exceptional care quality and efficiency rather than one that promotes competition and discourages providers from sharing best practices.
- Clear guidelines that to promote the application of appropriate use criteria and legal protections for providers who engage in quality improvement efforts.
- A period of predictable payment for physicians, without the threat of SGR-related cuts to allow physicians to develop and transition to alternative payment models that truly recognize the value and appropriateness of care rather than only compensating for the volume of delivered care.

It is this last point, the opportunity to develop alternative payment models during a so-called "period of stability," where I would like to focus my remaining comments. Inspired by this innovative proposal, STS convened our thought leaders and policy and registry experts to examine the procedures most frequently performed by STS members. Together we worked to craft team-based alternative payment models for the Heart Team and Lung Cancer Care Team in hopes that these models would provide a blue print for other care team models. For example, for the Heart Team Model, we considered an incremental approach to implementation that we believe will result in a longitudinal disease management bundled payment for Heart Team care.

We are confident that we can use the STS National Database, combined with other sources of administrative claims and quality information, to promote patient-centered, team-based care that rewards all members of the patient's care team for putting the patient first. This approach can improve patient outcomes and patient satisfaction while also improving care efficiency and saving money by enabling the care team to identify and provide the right treatment at the right time.

While our APM concepts are not yet finalized, I wanted to demonstrate to this Committee that the physician community is ready and eager for this opportunity. Unfortunately, as we wait for payment reform to become a reality, the Centers for Medicare and Medicaid Services (CMS) is implementing policy that will decimate the promised period of stability, stifle innovation, limit our ability to transition to a new APM, and destroy the only example of bundled payment that currently exists in the Medicare program. Specifically, CMS proposes to convert more than 4,000 10 and 90-day global surgical CPT codes to 0-day global codes by 2017 and 2018 respectively. Currently, cardiothoracic surgeons receive a single, bundled payment from Medicare for the surgeries they perform. That payment includes pre-operative consultation, the surgical procedure itself, all post-operative care in the hospital setting including monitoring patients' recovery and coordinating any medical specialty consultations, and outpatient visits up to 90 days after the procedure.

Despite the fact that the policy will affect 10-day global codes in 2017 and 90-day global codes in 2018, CMS has not yet developed a methodology for making this transition. Indeed, the agency has stated that it does not know how best to proceed. However, in order to implement the change, CMS must begin to transition all these codes no later than February 2016. Although

CMS will be gathering data on the number of post-operative services to more accurately value the individual services now included in the global, the Medicare Payment Advisory Commission estimates that data collection could take several years – well after the policy has already been implemented.

In addition to undermining the bipartisan, bicameral SGR legislation of the last Congress, the policy to transition 10- and 90-day global codes to 0-day has a number of potential consequences that should be well understood before implementation Specifically, eliminating global surgical payments will:

- Detract from quality of care, impede patient access, and complicate patient copays
    - Under the 10- and 90-day global codes, patients typically pay one copay related to all the services covered under the 10- or 90-day global code. If 10- and 90-day global codes are transitioned to 0-day global codes, patients will pay copays on other services as well, including each of the follow-up visits. This could considerably increase the administrative burden on patients, or worse, discourage them from coming back for follow-up care.
    - By unilaterally requiring that surgeons must bill separately for each individual service they provide, CMS is hampering our ability to ensure patients receive the best possible care. In the hospital critical care setting, the global payment structure allows the surgeon to oversee and coordinate care related to the patient's recovery. Without the global, care will be fragmented and providers will likely be forced to compete for the opportunity to see patients and bill for the care they provide. This may well lead to confusion by the patients as to levels of

responsibility and accountability of care, appropriateness of procedures and processes of care, and attribution in the event of adverse events from delivered care. In addition, without global payments, patients will be subject to copays for each post-operative visit. This could considerably increase the administrative burden on patients, or worse, discourage them from coming back for follow-up care. Further, if surgeons are not seeing their patients after the surgery, they won't be able to capture data in clinical registries which will hamper many of the innovations I described earlier.

- Obstruct clinical registry data collection and quality improvement
    - If patients forgo follow-up treatment or seek it from other providers, this policy would have a deleterious effect on surgeons' ability to collect information on patient outcomes in clinical registries, undermining many of the most meaningful quality improvement initiatives
- Increase administrative burden
    - The administrative burden on surgical practices and CMS (and its contractors) will be significant. The American Medical Association estimates that eliminating the global package will result in 63 million additional claims per year to account for post-surgical evaluation and management services. Clearly, this will add unnecessary costs to the claims processing system.

Conclusion

It is clear that current Medicare payment policy is fatally flawed. Furthermore, with the uncertainty of the current SGR paradigm, compounded by the global payments issues, innovation

and meaningful physician-led reform is nearly impossible. STS believes that the only way forward, for the benefit of patients and physicians alike, is a policy that allows for the development of alternative payment models. The STS is ready, willing, and able to take that next step, but first we need Congress to pass permanent Medicare physician payment reform. We urge Congress to act swiftly while the cost of SGR repeal is still relatively low, and to pass legislation that allows for the development of alternative payment models that will drive high quality health care and help Medicare beneficiaries to have access to the right care at the right time, every time.

Mr. PITTS. We are presently voting on the floor. We are still going to try to get a couple more of you in. So the chair recognizes Dr. Miller for 5 minutes.

STATEMENT OF KEN MILLER

Mr. MILLER. Thank you, Chairman Pitts, Ranking Member Green, and members of the committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners, the largest full-service professional membership organization for nurse practitioners of all specialties. With over 56,000 individual members and over 200 organization members, we represent the more than 205,000 nurse practitioners across the Nation.

My name is Ken Miller, and I currently serve as the president of the American Association of Nurse Practitioners. I am a family nurse practitioner, and previously served as the associate dean for academic administration at the Catholic University of America here in the District.

I am here to confirm our support of efforts to repeal the Medicare SGR, particularly SGR Repeal and Medicare Provider Payment Modernization Act of 2014 proposed in the last Congress.

As you know, nurse practitioners have been providing primary, acute, and specialty care for half a century and are rapidly becoming the healthcare provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to NPs in 2012, a number we anticipate will grow in the coming years. AANP strongly believes this serves as a testament to the trust that patients have in our workforce.

We commend the committee for their bipartisan legislative proposal, which recognizes all Part B providers, including nurse practitioners. Throughout the development of this legislation, the committee gave all stakeholders the opportunity to provide comments. This open process led to a strong bipartisan product, and this process should serve as a model as we move forward.

The legislation seeks to include all Medicare Part B providers by utilizing provider-neutral language. In addition, it includes a number of proposals that reflect the full partnership of nurse practitioners in the Medicare program, specifically the inclusion of nurse practitioners in the first year of the Merit-Based Incentive Payment System and ensuring that nurse practitioner-led Patient Centered Medical Homes are eligible to receive incentive payments for the management of patients with chronic disease.

Every day, increasing numbers of baby boomers become eligible for Medicare. Projections show that the number of beneficiaries are expected to increase by 20 million over the next 10 years, resulting in approximately 72 million patients being treated. Nurse practitioners are ready to do their part to ensure these patients receive timely, high-quality care.

According to the American Association of Colleges of Nursing, there are currently 63,000 students enrolled in nurse practitioner programs in the United States, with over 16,000 students graduating in 2014. Nurse practitioners provide care in nearly every healthcare setting, including clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices, both managed

and owned by NPs, nursing homes, schools, colleges, retail clinics, public health departments, nurse-managed clinics, and homeless clinics. It is important to remember that in many of these settings, nurse practitioners are the lead provider.

Nurse practitioners have continuously played a key role in treating Medicare beneficiaries, and since 1998 NPs have received direct reimbursement for providing Medicare Part B services in all settings. Nearly 85 percent of the current workforce are treating Medicare beneficiaries. Additionally, Medicare data shows that almost 17 percent of the beneficiaries in traditional fee-for-service coverage receive one or more services every year from NPs that bill Medicare directly.

The vast majority of NPs are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers, and over 75 percent currently practice in primary care settings. NPs bring a comprehensive perspective to health care by blending clinical experience in diagnosing and treating acute and chronic illnesses with an added emphasis on health promotion and disease preventions.

This comprehensive perspective is deeply rooted in nurse practitioner education. All NPs must complete a master's or doctoral program and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings.

Daily practice includes assessment, ordering, performing, supervising, and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment, including prescribing medication, as well as nonpharmacologic treatments, coordination of care, counseling, educating patients, their families, and communities.

In closing, the American Association of Nurse Practitioners would like to reiterate its support for the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 proposed in the last Congress. AANP is ready to provide support throughout the legislative process in the 114th Congress and looks forward to working with the committee and this Congress on the passage of this bill in 2015. Thank you.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Miller follows:]

STATEMENT
Of
Kenneth P. Miller, PhD, RN, CFNP, FAAN, FAANP
To
United States House of Representatives
Committee on Energy & Commerce
Subcommittee on Health
On
"A Permanent Solution to the SGR: The Time is Now"

January 22, 2015

Thank you Chairman Pitts, Ranking Member Green, and members of the Committee. I appreciate the opportunity to speak with you today on behalf of the American Association of Nurse Practitioners (AANP), the largest full service professional membership organization for nurse practitioners (NPs) of all specialties. With over 56,000 individual members and over 200 organization members, we represent the more than 205,000 nurse practitioners across the nation.

My name is Kenneth Miller. I am the current President of AANP. I am a family nurse practitioner and previously served as Associate Dean for Academic Administration at The Catholic University of America in Washington, DC, the Director of the School of Nursing for the University of Delaware and the Vice Dean for Internal Programs and Associate Dean for Research and Clinical Scholarship in the College of Nursing at the University of New Mexico Health Sciences Center.

On behalf of the American Association of Nurse Practitioners, I am here to confirm our support of efforts to repeal the Medicare SGR, particularly the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015) proposed in the last Congress. As you may

know, nurse practitioners have been providing primary, acute, and specialty care for half a century, and are rapidly becoming the health care provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to NPs in 2012, a number we anticipate will continue to grow in the coming years. AANP strongly believes this serves as a testament to the trust that patients have in our workforce. NPs practice in every community in this country, both urban and rural, and provide care to patients from all economic and social backgrounds.

Our data shows that the vast majority of NPs in the United States are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers and over seventy-five percent currently practice in primary care settings. NPs bring a comprehensive perspective to health care by blending clinical expertise in diagnosing and treating acute and chronic illnesses with an added emphasis on health promotion and disease prevention. This comprehensive perspective is deeply rooted in nurse practitioner education. All NPs must complete a master's or doctoral program, and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare them with specialized knowledge and clinical competency to practice in a variety of settings. Daily practice includes: assessment, ordering, performing, supervising and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment including prescribing medication (as well as non-pharmacologic treatments), coordination of care, counseling, educating patients, their families and communities.

NPs undergo rigorous national certification, periodic peer review, clinical outcome evaluations, and adhere to a strict code for ethical practice. Self-directed continued learning and professional development is also essential to maintaining clinical competence. It is important to note that NPs

are licensed in all states and the District of Columbia and practice under the rules and regulations of the state in which they are licensed. *The following documents are enclosed for your reference: NP Facts, Scope of Practice for Nurse Practitioners, Standards of Practice for Nurse Practitioners, Quality of Nurse Practitioner Practice, and Nurse Practitioner Cost Effectiveness.*

Nurse practitioners provide care in nearly every health care setting including clinics, hospitals, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics and homeless clinics. It is important to remember that in many of these settings nurse practitioners are the lead onsite provider. With nurse practitioners providing care in a wide variety of settings, they have continuously played a key role in treating Medicare beneficiaries. Nurse practitioners have received direct reimbursement for providing Medicare Part B services in all settings since 1998. Over 174,000 nurse practitioners, nearly eighty-five percent of the current NP workforce, are treating Medicare beneficiaries. Additionally, Medicare data shows that almost seventeen percent of beneficiaries in traditional fee-for-service coverage receive one or more services every year from NPs that bill Medicare directly. For many beneficiaries, especially rural and underserved populations, NPs are the only health care provider available.

Every day, increasing numbers of 'baby boomers" become eligible for Medicare. Projections show that the number of beneficiaries are expected to increase by 20 million over the next 10 years resulting in approximately 72 million patients being treated. Nurse practitioners are ready to do their part to ensure these patients receive timely high quality care. According to the American Association of Colleges of Nursing, there are currently 63,000 students enrolled in nurse practitioner programs in the United States with over 16,000 students graduating in 2014. Of those graduates, eighty-five percent were prepared in primary care. The evidence shows that

nurse practitioners comprise a highly educated and sustainable workforce that daily provides comprehensive care to the Medicare population. Recently, U.S. News & World Report ranked nurse practitioners as number two on their top ten list of "Best Jobs of 2015". The U.S. Department of Labor's Bureau of Labor Statistics predicts that the NP occupation will see tremendous growth between 2012 and 2022. As the size of the Medicare system continues to grow, nurse practitioners will continue to be in a position to care for the beneficiaries in all settings throughout the country, not only because of the current workforce, but because of their strong educational pipeline.

Today, the American Association of Nurse Practitioners reaffirms its support of the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015) proposed in the last Congress which would permanently repeal the flawed "sustainable growth rate" (SGR) formula for Medicare Part B and further reform the Medicare Payment System. We commend the Committee for their bipartisan legislative proposal which recognizes all Part B providers, including nurse practitioners. Throughout the development of this legislation, the Committee gave all stakeholders the opportunity to provide comments. This open process lead to a strong bipartisan product, and this process should serve as a model as we move forward. The overall focus of the legislation seeks to include all Medicare Part B providers by utilizing provider neutral language. In addition, it includes a number of proposals that reflect the full partnership of nurse practitioners in the Medicare Program; specifically, the inclusion of nurse practitioners in the first year of the Merit-based Incentive Payment System (MIPS), and ensuring that nurse practitioner led Patient Centered Medical Homes (PCMH) are eligible to receive incentive payments for the management of patients with chronic disease.

Additionally, it is our belief that repealing and replacing the current SGR formula will benefit both beneficiaries and providers in the Medicare system. Replacing the SGR methodology with a stable system of payments that fairly compensates all health care professionals will help to ensure the unobstructed delivery of the high quality, cost efficient services that Medicare beneficiaries need.

As Congress moves forward to address the current Medicare payment system, the American Association of Nurse Practitioners would like to reiterate its support for the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015) proposed in the last Congress. AANP is ready to provide support throughout the legislative process in the 114th Congress and looks forward to working with the Committee and this Congress on the passage of this bill in 2015. In the interest of the patients for whom we provide care, we strongly urge Congress to move to enact this legislation.

The American Association of Nurse Practitioners thanks the Committee for their work on this important issue, and we look forward to working together to repeal the Medicare SGR and reform Medicare Part B reimbursement policy to ensure patients have access to the health care they need. We thank you for your time, and we are pleased to continue to work together on this important issue in the days ahead.

Attachments:

1. AANP NP Facts
2. AANP Scope of Practice for Nurse Practitioners
3. AANP Standards of Practice for Nurse Practitioners
4. AANP Quality of Nurse Practitioner Practice
5. AANP Cost Effectiveness
6. APRN Workgroup H.R. 4015 support letter

AANP American Association of NURSE PRACTITIONERS℠

NP Facts

The Voice of the Nurse Practitioner®

There are more than 205,000 nurse practitioners (NPs) practicing in the U.S.

- An estimated 15,000 new NPs completed their academic programs in 2012-2013
- 95.1% of NPs have graduate degrees
- 96.8% of NPs maintain national certification
- 87.2% of NPs are prepared in primary care; 75.6% of NPs practice in at least one primary care site
- 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid
- 44.8% of NPs hold hospital privileges; 15.2% have long term care privileges
- 97.2% of NPs prescribe medications, averaging 19 prescriptions per day
- NPs hold prescriptive privilege in all 50 states and D.C., with controlled substances in 49
- The early-2011 mean, full-time NP base salary was $91,310, with average full-time NP total income $98,760
- The majority (69.5%) of NPs see three or more patients per hour
- Malpractice rates remain low; only 2% have been named as primary defendant in a malpractice case
- Nurse practitioners have been in practice an average of 11.7 years

Distribution, Mean Years of Practice, Mean Age by Population Focus

Population	Percent of NPs	Years of Practice	Age
Acute Care	6.3	7.7	46
Adult+	18.9	11.6	50
Family+	48.9	12.8	49
Gerontological+	3.0	11.6	53
Neonatal	2.1	12.2	49
Oncology	1.0	7.7	48
Pediatric+	8.3	12.4	49
Psych/Mental Health	3.2	9.1	54
Women's Health+	8.1	15.5	53

+Primary care focus

Sources:
AANP National NP Database, 2014
Fang, D., Li, Y., Bednash, G.D. (2014) 2012-2013 *Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing.* Washington DC: AACN
2012 AANP Sample Survey
2010 AANP National Practice Site Survey
2011 AANP National NP Compensation Survey

Additional information is available at the AANP website www.aanp.org.

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AANP American Association of NURSE PRACTITIONERS™

Scope of Practice for Nurse Practitioners

Professional Role

Nurse practitioners (NPs) are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families and groups accordant with their practice specialties. In addition to diagnosing and managing acute episodic and chronic illnesses, NPs emphasize health promotion and disease prevention. Services include ordering, conducting, supervising, and interpreting diagnostic and laboratory tests, prescribing pharmacological agents and non-pharmacologic therapies, and teaching and counseling patients, among others.

As licensed, independent clinicians, NPs practice autonomously and in collaboration with health care professionals and other individuals. They serve as health care researchers, interdisciplinary consultants and patient advocates.

Education

NPs are advanced practice nurses - health care professionals who have achieved licensure and credentialing well beyond their roles as registered nurses (RNs). All NPs obtain graduate degrees and many go on to earn additional post-master's certificates and doctoral degrees. Didactic and clinical courses provide NPs with specialized knowledge and clinical competency which enable them to practice in primary care, acute care and long-term care settings. Self-directed continued learning and professional development are hallmarks of NP education.

Accountability

The autonomous nature of NP practice requires accountability for health care outcomes and thus national certification, periodic peer review, clinical outcome evaluations, a code for ethical practice, evidence of continued professional development and maintenance of clinical skills. NPs are committed to seeking and sharing information that promotes quality health care and improves clinical outcomes. This is accomplished by leading and participating in both professional and lay health care forums, conducting research and applying findings to clinical practice.

Responsibility

The role of the NP continues to evolve in response to changing societal and health care needs. As leaders in primary and acute health care, NPs combine the roles of providers, mentors, educator, researchers and administrators. They also take responsibility for advancing the work of NPs through involvement in professional organizations and participation in health policy activities at the local, state, national and international levels.

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AANP American Association of NURSE PRACTITIONERS™

Standards of Practice for Nurse Practitioners

I. Qualifications

Nurse practitioners are licensed, independent practitioners who provide primary and/or specialty nursing and medical care in ambulatory, acute and long-term care settings. They are registered nurses with specialized, advanced education and clinical competency to provide health and medical care for diverse populations in a variety of primary care, acute and long-term care settings. Master's, post-master's or doctoral preparation is required for entry-level practice (AANP 2006).

II. Process of Care

The nurse practitioner utilizes the scientific process and national standards of care as a framework for managing patient care. This process includes the following components.

A. Assessment of health status

The nurse practitioner assesses health status by:

- Obtaining a relevant health and medical history
- Performing a physical examination based on age and history
- Performing or ordering preventative and diagnostic procedures based on the patient's age and history
- Identifying health and medical risk factors

B. Diagnosis

The nurse practitioner makes a diagnosis by:

- Utilizing critical thinking in the diagnostic process
- Synthesizing and analyzing the collected data
- Formulating a differential diagnosis based on the history, physical examination and diagnostic test results
- Establishing priorities to meet the health and medical needs of the individual, family, or community

C. Development of a treatment plan

The nurse practitioner, together with the patient and family, establishes an evidence-based, mutually acceptable, cost-awareness plan of care that maximizes health potential. Formulation of the treatment plan includes:

- Ordering and interpreting additional diagnostic tests
- Prescribing or ordering appropriate pharmacologic and non-pharmacologic interventions
- Developing a patient education plan
- Recommending consultations or referrals as appropriate

D. Implementation of the plan

Interventions are based upon established priorities. Actions by the nurse practitioners are:

- Individualized
- Consistent with the appropriate plan for care
- Based on scientific principles, theoretical knowledge and clinical expertise
- Consistent with teaching and learning opportunities

E. Follow-up and evaluation of the patient status

The nurse practitioner maintains a process for systematic follow-up by:

- Determining the effectiveness of the treatment plan with documentation of patient care outcomes
- Reassessing and modifying the plan with the patient and family as necessary to achieve health and medical goals

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III. Care Priorities

The nurse practitioner's practice model emphasizes:

A. Patient and family education
The nurse practitioner provides health education and utilizes community resource opportunities for the individual and/or family

B. Facilitation of patient participation in self care.
The nurse practitioner facilitates patient participation in health and medical care by providing information needed to make decisions and choices about:
- Promotion, maintenance and restoration of health
- Consultation with other appropriate health care personnel
- Appropriate utilization of health care resources

C. Promotion of optimal health

D. Provision of continually competent care

E. Facilitation of entry into the health care system

F. The promotion of a safe environment

IV. Interdisciplinary and Collaborative Responsibilities

As a licensed, independent practitioner, the nurse practitioner participates as a team leader and member in the provision of health and medical care, interacting with professional colleagues to provide comprehensive care.

V. Accurate Documentation of Patient Status and Care

The nurse practitioner maintains accurate, legible and confidential records.

VI. Responsibility as Patient Advocate

Ethical and legal standards provide the basis of patient advocacy. As an advocate, the nurse practitioner participates in health policy activities at the local, state, national and international levels.

VII. Quality Assurance and Continued Competence

Nurse practitioners recognize the importance of continued learning through:

A. Participation in quality assurance review, including the systematic, periodic review of records and treatment plans
B. Maintenance of current knowledge by attending continuing education programs
C. Maintenance of certification in compliance with current state law
D. Application of standardized care guidelines in clinical practice

VIII. Adjunct Roles of Nurse Practitioners

Nurse practitioners combine the roles of provider, mentor, educator, researcher, manager and consultant. The nurse practitioner interprets the role of the nurse practitioner to individuals, families and other professionals.

IX. Research as Basis for Practice

Nurse practitioners support research by developing clinical research questions, conducting or participating in studies, and disseminating and incorporating findings into practice.

AANP American Association of NURSE PRACTITIONERS™

Quality of Nurse Practitioner Practice

Nurse practitioners (NPs) are high quality health care providers who practice in primary care, ambulatory, acute care, specialty care, and long-term care. They are registered nurses prepared with specialized advanced education and clinical competency to provide health and medical care for diverse populations in a variety of settings. A graduate degree is required for entry-level practice. The NP role was created in 1965 and over 45 years of research consistently supports the excellent outcomes and high quality of care provided by NPs. The body of evidence supports that the quality of NP care is at least equivalent to that of physician care. This paper provides a summary of a number of important research reports supporting the NP.

Avorn, J., Everitt, D.E., & Baker, M.W. (1991). The neglected medical history and therapeutic choices for abdominal pain. A nationwide study of 799 physicians and nurses. Archives of Internal Medicine, 151(4), 694-698.
A sample of 501 physicians and 298 NPs participated in a study by responding to a hypothetical scenario regarding epigastric pain in a patient with endoscopic findings of diffuse gastritis. They were able to request additional information before recommending treatment. Adequate history-taking resulted in identifying use of aspirin, coffee, cigarettes, and alcohol, paired with psychosocial stress. Compared to NPs, physicians were more likely to prescribe without seeking relevant history. NPs, in contrast, asked more questions and were less likely to recommend prescription medication.

Bakerjian, D. (2008). Care of nursing home residents by advanced practice nurses: A review of the literature. Research in Gerontological Nursing, 1(3), 177-185.
Bakerjian conducted and extensive review of the literature, particularly of NP-led care. She found that long-term care patients managed by NPs were less likely to have geriatric syndromes such as falls, UTIs, pressure ulcers, etc. They also had improved functional status, as well as better managed chronic conditions.

Brown, S.A. & Grimes, D.E. (1995). A meta-analysis of nurse practitioners and nurse midwives in primary care. Nursing Research, 44(6), 332-9.
A meta-analysis of 38 studies comparing a total of 33 patient outcomes of NPs with those of physicians demonstrated that NP outcomes were equivalent to or greater than those of physicians. NP patients had higher levels of compliance with recommendations in studies where provider assignments were randomized and when other means to control patient risks were used. Patient satisfaction and resolution of pathological conditions were greatest for NPs. The NP and physician outcomes were equivalent on all other outcomes.

Congressional Budget Office. (1979). Physician extenders: Their current and future role in medical care delivery. Washington, D.C.: US Government Printing Office.
As early as 1979, the Congressional Budget Office reviewed findings of the numerous studies of NP performance in a variety of settings and concluded that NPs performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.

Cooper, M.A., Lindsay, G.M., Kinn, S., Swann, I.J. (2002). Evaluating emergency nurse practitioner services: A randomized controlled trial. Journal of Advanced Nursing, 40(6), 771-730.
A study of 199 patients randomly assigned to emergency NP-led care or physician-led care in the U.K. demonstrated the highest level of satisfaction and clinical documentation for NP care. The outcomes of recovery time, symptom level, missed work, unplanned follow-up, and missed injuries were comparable between the two groups.

Ettner, S.L., Kotlerman, J., Abdelmonem, A., Vazirani, S., Hays, R.D., Shapiro, M., et al. (2006). An alternative approach to reducing the costs of patient care? A controlled trial of the multi-disciplinary doctor-nurse practitioner (MDNP) model. Medical Decision Making, 26, 9-17.
Significant cost savings were demonstrated when 1207 patients in an academic medical center were randomized to either standard treatment or to a physician-NP model.

Horrocks, S., Anderson, E., Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. British Medical Journal, 324, 819-823.
A systematic review of 11 randomized clinical trials and 23 observational studies identified data on outcomes of patient satisfaction, health status, cost, and/or process of care. Patient satisfaction was highest for patients seen by NPs. The health status data and quality of care indicators were too heterogeneous to allow for meta-analysis, although qualitative

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comparisons of the results reported showed comparable outcomes between NPs and physicians. NPs offered more advice/information, had more complete documentation, and had better communication skills than physicians. NPs spent longer time with their patients and performed a greater number of investigations than did physicians. No differences were detected in health status, prescriptions, return visits, or referrals. Equivalency in appropriateness of studies and interpretations of x-rays were identified.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2006). Substitution of doctors by nurses in primary care. Cochrane Database of Systematic Reviews. 2006, Issue 1.
This meta-analysis included 25 articles relating to 18 studies comparing outcomes of primary care nurses (nurses, NPs, clinical nurse specialists, or advance practice nurses) and physicians. The quality of care provided by nurses was as high as that of the physicians. Overall, health outcomes and outcomes such as resource utilization and cost were equivalent for nurses and physicians. The satisfaction level was higher for nurses. Studies included a range of care delivery models, with nurses providing first contact, ongoing care, and urgent care for many of the patient cohorts.

Lenz, E.R., Mundinger, M.O., Kane, R.L., Hopkins, S.C., & Lin, S.X. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. Medical Care Research and Review 61(3), 332-351.
The outcomes of care in the study described by Mundinger, et al. in 2000 (see below) are further described in this report including two years of follow-up data, confirming continued comparable outcomes for the two groups of patients. No differences were identified in health status, physiologic measures, satisfaction, or use of specialist, emergency room, or inpatient services. Patients assigned to physicians had more primary care visits than those assigned to NPs.

Lin, S.X., Hooker, R.S., Lens, E.R., Hopkins, S.C. (2002). Nurse practitioners and physician assistants in hospital outpatient departments, 1997-1999. Nursing Economics, 20(4), 174-179.
Data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) were used to identify patterns of NP and PA practice styles. NPs were more likely to see patients alone and to be involved in routine examinations, as well as care directed towards wellness, health promotion, disease prevention, and health education than PAs, regardless of the setting type. In contrast , PAs were more likely to provide acute problem management and to involve another person, such as a support staff person or a physician.

Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W.Y., Cleary, P.D., et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. Journal of the American Medical Association, 283(1), 59-68.
The outcomes of care were measured in a study where patients were randomly assigned either to a physician or to an NP for primary care between 1995 and 1997, using patient interviews and health services utilization data. Comparable outcomes were identified, with a total of 1316 patients. After six months of care, health status was equivalent for both patient groups, although patients treated for hypertension by NPs had lower diastolic values. Health service utilization was equivalent at both 6 and 12 months and patient satisfaction was equivalent following the initial visit. The only exception was that at six months, physicians rated higher on one component (provider attributes) of the satisfaction scale.

Newhouse, R. et al (2011). Advanced practice nurse outcomes 1999-2008: A systematic review. Nursing Economic$, 29 (5), 1-22.
The outcomes of NP care were examined through a systematic review of 37 published studies, most of which compared NP outcomes with those of physicians. Outcomes included measures such as patient satisfaction, patient perceived health status, functional status, hospitalizations, ED visits, and bio-markers such as blood glucose, serum lipids, blood pressure. The authors conclude that NP patient outcomes are comparable to those of physicians.

Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse midwives: A policy analysis. Washington D.C.: US Government Printing Office.
The Office of Technology Assessment reviewed studies comparing NP and physician practice, concluding that, "NPs appear to have better communication, counseling, and interviewing skills than physicians have," (p. 19) and that malpractice premiums and rates supported patient satisfaction with NP care, pointing out that successful malpractice rates against NPs remained extremely rare.

Ohman-Strickland, P.A., Orzano, A.J., Hudson, S.V., Solberg, L.I., DiCiccio-Bloom, B., O'Malley, D., et al. (2008). Quality of diabetes care in family medicine practices: Influence of nurse-practitioners and physician's assistants. Annals of Family Medicine, 6(1), 14-22.
The authors conducted a cross-sectional study of 46 practices, measuring adherence to ADA guidelines. They reported that practices with NPs were more likely to perform better on quality measures including appropriate measurement of glycosylated hemoglobin, lips, and microalbumin levels and were more likely to be at target for lipid levels.

Prescott, P.A. & Driscoll, L. (1980). Evaluating nurse practitioner performance. Nurse Practitioner, 1(1), 28-32.
The authors reviewed 26 studies comparing NP and physician care, concluding that NPs scored higher in many areas. These included: amount/depth of discussion regarding child health care, preventative health, and wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and follow-up on history findings; completeness of physical examination and interviewing skills; and patient knowledge of the management plan given to them by the provider.

Roblin, D.W., Becker, R., Adams, E.K., Howard, D. H., & Roberts, M.H. (2004). Patient satisfaction with primary care: Does type of practitioner matter? Medical Care, 42(6), 606-623.
A retrospective observational study of 41,209 patient satisfaction surveys randomly sampled between 1997 and 2000 for visits by pediatric and medicine departments identified higher satisfaction with NP and/or PA interactions than those with physicians, for the overall sample and by specific conditions. The only exception was for diabetes visits to the medicine practices, where the satisfaction was higher for physicians.

Sackat, D.L., Spitzer, W. O., Gent, M., & Roberts, M. (1974). The Burlington randomized trial of the nurse practitioner: Health outcomes of patients. Annals of internal Medicine, 80(2), 137-142.
A sample of 1598 families were randomly allocated, so that two-thirds continued to receive primary care from a family physician and one-third received care from a NP. The outcomes included: mortality, physical function, emotional function, and social function. Results demonstrated comparable outcomes for patients, whether assigned to physician or to NP care. Details from the Burlington trial were also described by Spitzer, et al (see below).

Safriet, B. J. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9(2).
The full Summer 1992 issue of this journal was devoted to the topic of advanced practice nursing, including documenting the cost-effective and high quality care provided, and to call for eliminating regulatory restrictions on their care. Safriet summarized the OTA study concluding that NP care was equivalent to that of physicians and pointed out that 12 of the 14 studies reviewed in this report which showed differences in quality reported higher quality for NP care. Reviewing a range of data on NP productivity, patient satisfaction, and prescribing, and data on nurse midwife practice, Safriet concludes "APNs are proven providers, and removing the many barriers to their practice will only increase their ability to respond to the pressing need for basic health care in our country" (p. 487).

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, M., Gent, M., Kergin, D.J., Hacket, B.D., & Olynich, A. (1974). The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine, 290 (3), 252-256.
This report provides further details of the Burlington trial, also described by Sackett, et al. (see above). This study involved 2736 patients being randomly assigned to either one of two physicians or to an NP, so that one-third were assigned to NP care, from July 1971 to July 1972. At the end of the period, physical status and satisfaction were comparable between the two groups. The NP group experienced a 5% drop in revenue, associated with absence of billing for NP care. It was hypothesized that the ability to bill for all NP services would have resulted in an actual increased revenue of 9%. NPs functioned alone in 67% of their encounters. Clinical activities were evaluated and it was determined that 69% of NP management was adequate compared to 66% for the physicians. Prescriptions were rated adequate for 71% of NPs compared to 75% for physicians. The conclusion was that "a nurse practitioner can provide first-contact primary clinical care as safely and effectively as a family physician" (p. 255).

AANP American Association of NURSE PRACTITIONERS™

Nurse Practitioner Cost-Effectiveness

Nurse Practitioners (NPs) are a proven response to the evolving trend towards wellness and preventive health care driven by consumer demand. A solid body of evidence demonstrates that NPs have consistently proven to be cost-effective providers of high-quality care for almost 50 years. Examples of the NP cost-effectiveness research are described below.

Over three decades ago, the Office of Technology Assessment (OTA) (1981) conducted an extensive case analysis of NP practice, reporting that NPs provided equivalent or improved medical care at a lower total cost than physicians. NPs in a physician practice potentially decreased the cost of patient visits by as much as one third, particularly when seeing patients in an independent, rather than complementary, manner. A subsequent OTA analysis (1986) confirmed original findings regarding NP cost effectiveness. All later studies of NP care have found similar cost-efficiencies associated with NP practice.

The cost-effectiveness of NPs begins with their academic preparation. The American Association of Colleges of Nursing has long reported that NP preparation cost 20-25% that of physicians. In 2009, the total tuition cost for NP preparation was less than one-year tuition for medical (MD or DO) preparation (AANP, 2010).

Comparable savings are associated with NP compensation. In 1981, the hourly cost of an NP was one-third to one-half that of a physician (OTA). The difference in compensation has remained unchanged for 30 years. In 2010, when the median total compensation for primary care physicians ranged from $208,658 (family) to $219,500 (internal medicine) (American Medical Group Association, 2010), the mean full-time NP's total salary was $97,345, across all types of practice (American Academy of Nurse Practitioners [AANP], 2010). A study of 26 capitated primary care practices with approximately two million visits by 206 providers determined that the practitioner labor costs and total labor costs per visit were both lower in practices where NPs and physician assistants (PAs) were used to a greater extent (Roblin, Howard, Becker, Adams, and Roberts, 2004). When productivity measures, salaries, and costs of education are considered, NPs are cost effective providers of health services.

Based on a systematic review of 37 studies, Newhouse et al (2011) found consistent evidence that cost-related outcomes such as length of stay, emergency visits, and hospitalizations for NP care are equivalent to those of physicians. In 2012, modeling techniques were used to predict the potential for increased NP cost-effectiveness into the future, based on prior research and data. Using Texas as the model State, Perryman (2012) analyzed the potential economic impact that would be associated with greater use of NPs and other advanced practice nurses, projecting over $16 billion in immediate savings which would increase over time.

NP cost-effectiveness is not dependent on actual practice setting and is demonstrated in primary care, acute care, and long term care settings. For instance, NPs practicing in Tennessee's state-managed managed care organization (MCO) delivered health care at 23% below the average cost associated with other primary care providers, achieving a 21% reduction in hospital inpatient rates and 24% lower lab utilization rates compared to physicians (Spitzer, 1997). A one-year study comparing a family practice physician-managed practice with an

NP-managed practice within an MCO found that compared to the physician practice, the NP-managed practice had 43% of the total emergency department visits, 38% of the inpatient days, and 50% total annualized per member monthly cost (Jenkins and Torrisi, 1995). Nurse managed centers (NMCs) with NP-provided care have demonstrated significant savings, less costly interventions, and fewer emergency visits and hospitalizations (Hunter, Ventura, and Keams, 1999; Coddington and Sands, 2009). A study conducted in a large HMO setting established that adding an NP to the practice could virtually double the typical panel of patients seen by a physician with a projected increase in revenue of $1.28 per member per month, or approximately $1.65 million per 100,000 enrollees annually (Burl, Bonner, and Rao, 1994).

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Chenowith, Martin, Pankowski, and Raymond (2005) analyzed the health care costs associated with an innovative on-site NP practice for over 4000 employees and their dependents, finding savings of $ .8 to 1.5 million, with a benefit-to-cost ratio of up to 15 to 1. Later, they tested two additional benefit-to-cost models using 2004-2006 data for patients receiving occupational health care from an NP demonstrating a benefit to cost ratio ranging from 2.0-8.7 to 1, depending on the method (Chenowith, Martin, Pankowski, and Raymond (2008). Time lost from work was lower for workers managed by NPs, compared to physicians, as another aspect of cost-savings (Sears, Wickizer, Franklin, Cheadle, and Berkowitz, 2007).

A number of studies have documented the cost-effectiveness of NPs in managing the health of older adults. Hummel and Prizada (1994) found that compared to the cost of physician-only teams, the cost of a physician-NP team long term care facility were 42% lower for the intermediate and skilled care residents and 26% lower for those with long-term stays. The physician-NP teams also had significantly lower rates of emergency department transfers, shorter hospital lengths of stay, and fewer specialty visits. A one-year retrospective study of 1077 HMO enrollees residing in 45 long term care settings demonstrated a $72 monthly gain per resident, compared with a $197 monthly loss for residents seen by physicians alone (Burl, Bonner, Rao, and Kan, 1998). Intrator (2004) found that residents in nursing homes with NPs were less likely to develop ambulatory care-sensitive diagnoses requiring hospitalizations. Bakerjian (2008) summarized a review of 17 studies comparing nursing home residents who are patients of NPs to others, finding lower rates of hospitalization and overall costs for the NP patients. The potential for NPs to control costs associated with the healthcare of older adults was recognized by United Health (2009), which recommended that providing NPs to manage nursing home patients could result in $166 billion healthcare savings.

NP-managed care within acute-care settings is also associated with lower costs. Chen, McNeese-Smith, Cowan, Upenieks, and Afifi (2009) found that NP-led care was associated with lower overall drug costs for inpatients. When Paez and Allen (2006) compared NP and physician management of hypercholesterolemia following revascularization, they found patients in the NP-managed group had lower drug costs, while being more likely to achieve their goals and comply with prescribed regimen.

Collaborative NP/physician management was associated with decreased length of stay and costs and higher hospital profit, with similar readmission and mortality rates (Cowan et al., 2006; Ettner et al., 2006). The introduction of an NP model in a health system's neuroscience area resulted in over $2.4 million savings the first year and a return on investment of 1600 percent; similar savings and outcomes were demonstrated as the NP model was expanded in the system (Larkin, 2003). Boling (2009) cites an intensive short-term transitional care NP program documented by Smigleski et al through which healthcare costs were decreased by 65% or more after enrollment, as well as the introduction of an NP model in a system's cardiovascular area associated with a decrease in mortality from 3.7% to 0.6% and over 9% decreased cost per case (from $27,037 to $24,511).

In addition to absolute cost, other factors are important to health care cost-effectiveness. These include illness prevention, health promotion, and outcomes. See Documentation of Quality of Nurse Practitioner Practice (AANP, 2013) for further discussion.

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January 20, 2015

Hon. Joe Pitts, Chairman
House Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Hon. Gene Green, Ranking Member
House Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
2415 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

In anticipation of your January 21-22 hearings titled, "A Permanent Solution to the SGR: The Time is Now," we write as organizations representing roughly 340,000 Advanced Practice Registered Nurses (APRNs) in the United States in support of permanent SGR repeal and the Medicare reforms included in HR 4015 considered by the 113th Congress. Repealing the Medicare sustainable growth rate (SGR) and reforming Medicare Part B payment are long overdue. In the interest of the patients for whom we provide care, we strongly support Congress moving to enact legislation providing permanent SGR repeal and Medicare payment reforms. Payment reforms should recognize APRNs the same as physicians in reimbursement and in the development and implementation of quality measures for payment incentives when the same quality services are provided.

Our APRN Workgroup is comprised of organizations representing Nurse Practitioners (NPs) delivering primary, specialized and community healthcare; Certified Registered Nurse Anesthetists (CRNAs) who provide the full range of anesthesia services as well as chronic pain management; Certified Nurse-Midwives (CNMs) expert in primary care, maternal and women's health; and Clinical Nurse Specialists (CNSs) offering acute, chronic, specialty and community healthcare services. Totaling roughly 340,000 healthcare professionals, including two of the ten largest categories of Medicare Part B provider specialties according to Medicare claims data, our primary interests are patient wellness and improving patient access to safe and cost-effective healthcare services. In every setting and region, for every population particularly among the rural and medically underserved, America's growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost-effective healthcare delivery.

APRNs provide crucial care to patients in every environment that healthcare is delivered, contribute to community health and healthcare delivery for populations, and engage in leadership activities necessary to promote patient access to better healthcare and cost savings. The care that our members provide includes services billed directly to Part B, services bundled into hospital or other facility claims, services billed "incident-to" the services of a physician and reported by the physician not the APRN providing the care, and population and community healthcare. **Thus, as Congress works on legislation to repeal the SGR and reform the Medicare payment system, we ask on behalf of the patients for whom we provide care that you keep this in mind: Nurses will always put patients first.**

APRNs Support Repealing the SGR and Reforming Medicare Payment

Because Medicare covers APRN services under Part B, we join in expressing support for repeal of Medicare SGR cuts that frequently threaten Medicare beneficiaries, providers and the Medicare program with unsustainable and draconian cuts. Over the next 10 years the Medicare population will increase by 20 million beneficiaries to 72 million. We look forward to continuing work with you to enact legislation that stabilizes Medicare payment and promotes innovations that increase quality and access and help control healthcare cost growth, and to addressing the issues associated with its costs.

In *The Future of Nursing: Leading Change, Advancing Health* report, the Institute of Medicine's (IOM) first recommendation is for APRNs to practice to the fullest scope of their education and training, and its third is to expand opportunities for RNs and APRNs to develop and exercise leadership in redesigning healthcare in the United States. The IOM recommends policymakers eliminate barriers to the fullest and best use of APRNs, not only so that they can practice to the fullest extent of their license but also to provide for the growing number of Medicare beneficiaries and other patients' access to high quality, cost-effective care. This action is a crucial imperative at every level of healthcare policy from Congress and the Administration, to states, to healthcare facilities and private enterprise, and in every part of our country, particularly rural and medically underserved America which rely heavily on APRN care. Failure to make the highest and best use of APRNs by protecting unnecessary and costly guild-driven barriers to their care denies patient access to quality care, limits healthcare improvement, and wastes taxpayer and private resources.

We hope that the legislative process would support fair consideration and funding of a positive update for fee for service providers. We also request that further consideration of offsetting revenue sources for this legislative package promote sound healthcare policy. We support improvements to the 113th Congress legislation that promote patient access to safe, cost-effective healthcare by recognizing APRNs so that they may practice at their full scope and exercise leadership in healthcare transformation – recommendations consistent with the IOM report. Furthermore, we would request lawmakers oppose any amendments that would impair patient access to APRNs practicing to their full scope, and any anesthesia policy related amendments that do not have the support of national organizations representing CRNAs and anesthesiologists.

Thank you for your consideration, and we look forward to continuing to engage with you in support of legislation permanently repealing the cycle of SGR cuts that harm healthcare and reforming Medicare payment to promote access to quality care. If you have any questions, please contact Frank Purcell at the AANA Washington office, 202-484-8400, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing

American Association of Nurse Anesthetists

American Association of Nurse Practitioners

American College of Nurse-Midwives

American Nurses Association
Gerontological Advanced Practice Nurses Association
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Organization of Nurse Practitioner Faculties

Mr. PITTS. Dr. McAneny, you are recognized for 5 minutes.

STATEMENT OF BARBARA MCANENY

Dr. MCANENY. Thank you, Chairman Pitts and Ranking Member Green, members of the committee. My name is Barbara McAneny, and I am an oncologist from Albuquerque, New Mexico, and I am chair of the American Medical Association Board of Trustees.

The AMA believes that the Medicare sustainable growth rate formula, the SGR, presents one of the most important yet difficult challenges our healthcare system faces today. We commend this committee for its extensive work in the last Congress and for taking this first step in the 114th Congress to resolve this issue.

The time is ripe for Congress to finish the task of repealing the SGR and replace it with payment reforms that enhance and support patient care. Congress should act quickly to enact the SGR Repeal and Medicare Provider Payment Modernization Act reported by this committee in the 113th Congress by a vote of 51 to 0 as part of a thoughtful, bipartisan, and bicameral process.

This legislation represents an end to the fundamentally flawed SGR formula, which is a major barrier to the development and adoption of healthcare payment and delivery reforms that can improve the care for our Nation's seniors and the disabled while reducing overall spending. Also, TRICARE is tied to Medicare payments, so our Nation's military and their families will also benefit from its passage.

The reforms included in this legislation enjoy the strong support of an array of stakeholders, including over 600 State, specialty and national medical associations, as well as organizations representing the interest of patients.

Under this proposal, physicians who join new payment models would be supported in their transition into new models of care delivery that would improve the quality and deliver more coordinated care while saving the Medicare system money. There are now 424 accountable care organizations serving over 7.8 million Medicare beneficiaries, and this has saved Medicare $417 million. The committee proposal would expand our ability as physicians to develop and participate in even more innovative ideas.

Right now physicians are facing a tsunami of penalties from the various Medicare quality reporting programs: PQRS, Meaningful Use, and the Value-Based Payment Modifier. Under the committee proposal, we would report under one streamlined program known as the Merit-Based Incentive Payment System, or MIPS. We would no longer be forced to divert our attention and our resources towards complying with overlapping and often conflicting programs. Instead, we could focus those resources on making meaningful changes in our practices that benefit our patients.

We need the flexibility that the MIPS program provides so that we would be free to demonstrate our quality of care according to the standards that match our specialty and our type of practice. Therefore, the committee proposal does far more than merely replacing the SGR, it is an important step forward to help physicians to successfully restructure our practices to provide better care at a lower cost.

Please take this opportunity to build upon the progress that your committee has already made by continuing to work in a bipartisan manner to resolve the remaining barriers to these significant policy reforms.

Everyone agrees that we need to contain Medicare spending, but the SGR was never the solution and it simply has not worked. The 17 SGR patches enacted since 2003 have cost the Federal Government over $169 billion, which is far more than the CBO's estimate of this committee's proposal. So the time to replace the SGR is now.

We understand that the pathway forward must have the necessary bipartisan support to pass both chambers and to be signed into law by the President. Almost 10 months have passed since Congress set the latest deadline to enact the legislation, and time is running short. We urge this committee to commence negotiations to resolve these remaining questions. Only Congress can find the common ground to resolve the outstanding budgetary issues.

We are very appreciative of the committee's leadership on Medicare physician payment reform, and the AMA stands ready to be a constructive partner. We thank you very much for the opportunity to share our views.

Mr. PITTS. Thank you very much.

[The prepared statement of Dr. McAneny follows:]

Statement

of the

American Medical Association

to the

Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives

Re: Permanent Solution to the SGR: The Time is Now

Presented by Barbara L. McAneny, MD
Chair, AMA Board of Trustees

January 22, 2015

Division of Legislative Counsel
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STATEMENT

of the

American Medical Association

to the

Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives

Re: A Permanent Solution to the SGR: The Time is Now

Presented by Barbara L. McAneny, MD
Chair, AMA Board of Trustees

January 22, 2015

On behalf of the American Medical Association (AMA), I commend the Energy & Commerce Committee Subcommittee on Health for conducting this hearing to address "A Permanent Solution to the SGR: The Time is Now." As the largest professional association for physicians and the umbrella organization for state and specialty medical societies, the AMA is dedicated to promoting the art and science of medicine and the betterment of public health. We commend the Subcommittee for taking the first step in the 114th Congress to address this matter.

The time is past for Congress to move forward with a legislative solution that resolves a longstanding and fundamental problem facing Medicare by repealing the statutory formula known as the Sustainable Growth Rate, or SGR, and replacing it with payment reforms that enhance and support patient care. Congress should act expeditiously to enact the policies in the comprehensive, bipartisan, bicameral "SGR Repeal and Medicare Provider Payment Modernization Act," (H.R. 4015/S. 2000 in the 113th Congress).

We now have a unique opportunity to improve and modernize Medicare by enacting into law legislation based upon H.R. 4015/S. 2000. This bill represents significant Medicare reform, and the Subcommittee

should continue to build on this effort by addressing outstanding barriers to its successful passage. There should be no preconditions, other than the commitment to a bipartisan and workable solution that can withstand scrutiny and be passed by both houses of Congress, signed by the President, and become law.

In 1997, Medicare law was amended to include the SGR formula, which requires cuts in payment for physician services when annual spending under the Medicare Physician Fee Schedule exceeds certain targets that are tied to economic growth. These "physician services"—which also include services by non-physician practitioners who are paid under the Medicare Physician Fee Schedule/Part B—are the only Medicare services subject to these kinds of cuts. There is no SGR formula or other comparable ceiling that triggers cuts in Medicare reimbursement for hospitals, ambulatory surgical clinics, home health, hospice, pharmaceuticals, medical devices and supplies, or any other category of Medicare provider or supplier.

Everyone agrees that we need to contain Medicare spending and ensure the most efficient and effective use of Medicare resources. Unfortunately, the Medicare SGR formula was never the solution, and in fact has now added to the problem. Physicians are not solely responsible for Medicare spending levels. Physicians order and recommend health care services and treatments, but they do not establish (or sometimes even know) the prices of those services. A wide array of factors and services contribute to Medicare spending levels, including patient choices and decisions. In 2013, Medicare spending on Part B Physician Fee Schedule services was $69 billion, or 12 percent of total Medicare spending.[1] And many physician services are designed to keep patients out of the hospital. Cuts produced under the SGR affect payment and compensation for over a million health care professionals, including physicians, non-physician practitioners (such as nurse practitioners and physician assistants), and the nurses and other staff they employ.

[1] 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, at 11.

This Medicare formula has undermined and destabilized the practice of medicine and prevented physicians from focusing on their patients. It also has prevented physicians from engaging in payment and delivery reforms, and it has taken time and energy away from innovations that can improve the quality of care. If not remedied soon, access to care will be threatened. For example, the number of psychiatrists accepting Medicare patients has plummeted in recent years, to just over 50 percent, while the growing numbers of patients with dementia and depression are facing a severe shortage of mental health providers.[2]

Physicians already face an enormous gap between what Medicare pays and the actual cost of caring for seniors and the disabled. From 2001 to 2015, government data show that the cost of caring for patients by medical practices has gone up by 27 percent. At the same time, the average annual Medicare physician payment update has been only about 0.3 percent per year. Adjusting for inflation, the physician payment rate has actually fallen by 18 percent. With enormous debt burdens for graduating medical students,[3] and increasing regulatory burdens for electronic health records, physician quality reporting programs, ICD-10, etc., we continue to hear from physicians who are retiring early, choosing to go into administration or business instead of seeing patients, or advising their children not to become physicians. The Medicare SGR formula adds to this problem by threatening steep payment cuts year after year, and AMA members have repeatedly identified SGR reform as our highest priority. Physicians are also facing a tsunami of penalties from the various overlapping Medicare programs. The cumulative effect of these programs, when combined with a two percent payment sequester reduction, would produce penalties totaling 11 percent in 2017 and grow to 13 percent by the end of this decade.

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[2] *JAMA Psychiatry*. 2014; 71(2):176-181. doi:10.1001/jamapsychiatry.2013.2862.
[3] The AMA estimates the average debt burden for medical school graduates at approximately $180,000.

The current fee-for-service payment system creates major barriers for physicians who want to redesign care in ways that benefit patients and save money for Medicare:

- **Financial penalties for delivering higher-value care**: Today, physicians are financially penalized for reducing unnecessary services and improving quality. Under the current Medicare payment system, physicians lose revenue if they perform fewer procedures or lower cost procedures, even if their patients are healthier as a result. Most fundamentally, under Medicare, physicians are not paid at all when their patients stay well.
- **Failure to pay for high-value services**: In the Medicare program, some high-value services are not paid for adequately or at all. Medicare does not pay physicians to respond to a patient phone call about a symptom or problem, even though those phone calls can avoid far more expensive visits to the emergency room. Medicare will not pay primary care physicians and specialists to coordinate care by telephone or email, yet it will pay for duplicate tests and the problems caused by conflicting medications.

Physicians all over the country have proven that they can both improve care for patients and save money for Medicare if they can get the resources they need to deliver services that Medicare does not pay for. For example, primary care physicians, cardiologists, oncologists, and others have used grant funding in demonstration projects to pay for nurses to help patients manage their health problems. These projects have dramatically reduced the rate at which their patients have had to go to an emergency room or be hospitalized for complications, saving Medicare far more than the cost of the services supported by the grants. But in most cases, the improvements in care and the savings achieved in the demonstration projects end when the demonstration ends, because there is no way to sustain the projects under the current payment system. The payment reforms adopted by the Committee last year would help remove these barriers and promote adoption of new payment models that will improve patient care and lower costs.

On 17 separate occasions in the past 12 years, Congress has agreed that the Medicare SGR formula is not working. Seventeen temporary "patches" have been enacted since 2003 to prevent SGR cuts from taking effect. But every time a patch is enacted, the cut is simply postponed and added to the following year. As a result, the projected cut that is scheduled to take effect on April 1, 2015, is 21.2 percent, unless Congress intervenes. Due to nearly flat utilization growth in physician services for several years, the SGR "cliff" has dropped from almost 30 percent a few years ago to 21.2 percent effective in April 2015. If we could ignore the accumulated 21 percent cliff, the Medicare SGR formula would actually trigger an increase in payment for physician services, as recent spending has actually been running below SGR targets. Per enrollee, SGR spending has averaged less than one percent in recent years, and for 2013 SGR spending was six percent below the target amount.

There has long been widespread support for repealing the Medicare SGR formula, including from the Medicare Payment Advisory Commission. Just last week at the Commission's January meeting, Chair Glenn Hackbarth "exhorted lawmakers" to put a permanent end to the SGR formula that "routinely threatens to slash doctors' pay from the big government health program." Mr. Hackbarth pointed out that Congress has frequently used savings from Medicare to offset budget deals and temporary SGR patches. "Yet we never seem to have enough to pay for an appropriate payment system for physicians," he said.

The House of Representatives is in session only 28 days before SGR Patch Number 17 expires on March 31. Unless Congress takes action now, there will again be scrambling at the last minute to enact yet another "Band-Aid" patch. Even the Congressional Budget Office (CBO) agrees that the patches have cost Medicare more over time (not even counting the work of Congress and other stakeholders) than if Congress had acted quickly to repeal the Medicare SGR formula. In November 2014, the CBO estimated the 10-year cost of enacting H.R. 4015/S. 2000 at $144 billion. By contrast, the cumulative cost of the patches since 2003 is estimated at $169.5 billion.

The AMA commends the members and staff of the House Energy & Commerce, House Ways & Means, and Senate Finance Committees for developing comprehensive bipartisan, bicameral legislation—with input from stakeholders—to enact permanent Medicare reform and permanently repeal the Medicare formula. We encourage this Committee and the new Congress to move this legislation forward as quickly as possible. H.R. 4015/S. 2000 provides a pathway forward to achieving meaningful Medicare reform. It represents a historic achievement in this effort. There has long been strong bipartisan agreement that the Medicare SGR formula must be repealed and replaced with an alternative, more viable system. After working for over a year, Republican and Democratic members and staff of these three committees were able to come to agreement on a single bill, and each committee approved the bill. The House Energy and Commerce Committee approved H.R. 4015 unanimously, 51 to zero.

H.R. 4015/S. 2000 is a detailed, thoughtful, and workable solution. It represents a major improvement over current law, and it is widely supported by physician specialty organizations. In addition to permanently repealing the SGR, it would provide positive payment updates of 0.5 percent for the first five years, and then freeze payments at that level for an additional five years to allow for the development and adoption of new, innovative payment and delivery models. Payments in subsequent years would be determined by many factors, including performance in the newly created Merit-Based Incentive Payment System (MIPS) for those who choose to remain in the fee-for-service payment system. Physicians in qualifying alternative payment models would receive a five percent bonus for a five-year period. The MIPS program would harmonize the various Medicare quality reporting programs: the Physician Quality Reporting System (PQRS), Electronic Health Record Incentive Program/Meaningful Use (MU), and the Value-Based Payment Modifier (VBM). The distinct requirements of these individual programs are often contradictory and duplicative, and together impose an unreasonably high burden and unduly high penalties on physicians, without clear evidence that they actually improve the quality of care. The bill streamlines key features of these programs into one single, more workable and practical program that offers greater flexibility and more opportunities for physicians to be rewarded for providing quality care.

Performance scoring under the MIPS program has several advantages over the current penalty programs:

- Unlike the VBM, the MIPS would not require both winners and losers. In the MIPS, physicians who meet the performance threshold would avoid a penalty, and those who exceed it would earn bonuses.
- Performance assessment under the MIPS program would be according to a "sliding scale"—versus the current "all or nothing" approaches used in PQRS and MU. Credit would be provided to those who partially meet the performance metrics.
- The bill has guidelines for the weighting of the four performance categories, yet specifically allows administrative flexibility for those in practices or specialties that are at a disadvantage in meeting quality or MU requirements.
- At the start of each performance period, physicians would know the threshold score for successful performance, and they would receive quarterly feedback on their individual performance.
- Physicians could receive substantial credit for clinical practice improvement activities and for improving (and achieving) quality of care.
- Physicians with a low level of Medicare claims, and those who are in alternative models, would be exempt from the MIPS requirements and payment adjustments.

The MIPS also presents the first real opportunity for physicians to earn substantial bonuses for providing high quality of care. For exceeding the performance threshold, physicians could earn bonuses of up to four percent the first year, with the maximum increasing by one percent each year until reaching nine percent in year six and beyond. Additional funding is provided for exceptional performance, up to $500 million per year, in years eight through ten. So even if all physicians score above the threshold, some will still receive incentive payments. Unlike current law, the MIPS penalties provide greater certainty, and have a maximum range in future years.

The bill provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians participating in patient centered medical homes, widely recognized to lower costs of care, would not be required to assume downside financial risk. Other models would require some degree of downside risk in addition to opportunities for increased revenues if the physician practice generates savings. To encourage physicians to take on this risk, and provide a financial cushion, the legislation provides five percent bonus payments for five years for those who join new models. This provides a transition period to support successful implementation of new models. Another advantage is that physicians would only be subject to the quality reporting requirements for their model of care; they would be exempt from the new MIPS quality program. The bill also supports the use of telemedicine in new models of care and creates an advisory panel to consider physicians' proposals for new models.

New payment and delivery models can make Medicare services more effective and more efficient, thereby saving money while improving care. Many of these savings are difficult to demonstrate, and occur in the long-term, beyond the period reviewed by the CBO. But the leading experts in health care payment and efficiency embrace alternative payment models as the best way to make Medicare a stronger, more efficient program, and present an alternative to the current fee-for-service approach which inherently rewards quantity of services, over quality and effectiveness of services. Moreover, the Centers for Medicare & Medicaid Services (CMS) recently reported there are now 424 accountable care organizations (ACOs) serving over 7.8 million beneficiaries under the Medicare Shared Savings Program and the Pioneer ACO Model, producing total savings of $417 million.[4]

The Committee's proposal has the broad support of providers, patients, and other stakeholders. More than 600 state, specialty, and national medical societies signed a letter to Congress urging its passage. A

[4] Sean Cavanaugh, Deputy Administrator and Director, Center for Medicare. The CMS Blog: ACOs Moving Ahead. Dec. 22, 2014. http://blog.cms.gov/.

broad array of patient and other groups, from AARP to Easter Seals to the U.S. Chamber of Commerce, also wrote to Congress in November 2014, in support of the bill.

The AMA stands ready to support this process. Now is the time to move toward a Medicare program that supports physicians for providing high-quality care that helps keep their patients out of the hospital. A 21st Century health care system focuses on patients, not just payments.

The AMA appreciates the opportunity to provide our comments on this critical health policy matter, and we look forward to working with the Subcommittee and Congress to repeal the flawed SGR formula and assist in the transition to a new health care payment and delivery system that provides more coordinated care, improves health outcomes, and slows the growth of costs in the Medicare program.

Mr. PITTS. We have got 1 minute left in the vote. We still have 260 people not voting. We will try the last one. So, Dr. Schneidewind, you are recognized for 5 minutes.

STATEMENT OF ERIC SCHNEIDEWIND

Mr. SCHNEIDEWIND. Chairman Pitts, Ranking Member Green, and members of the committee, thank you for holding this hearing on reforming Medicare physician reimbursement and for inviting AARP to speak from the Medicare beneficiary's perspective.

My name is Eric Schneidewind and I am the AARP president-elect. AARP is a nonpartisan organization of over 38 million members ages 50-plus, many of whom are Medicare beneficiaries. During the previous Congress, AARP was pleased to work with committee staff from both chambers and both parties in developing what became H.R. 4015.

Permanently repealing the sustainable growth rate formula will bring stability and predictability to healthcare providers and Medicare beneficiaries. The reimbursement reforms in the bicameral bill are a significant step toward improving quality and value. We applaud the move toward more coordinated care, the streamlined quality measurement and reporting system, and greater data transparency. Thanks to the tireless work of many of the legislators and staff here today, we are closer than we have ever been to finally replacing this broken reimbursement system.

However, the final bill introduced last Congress did not include important health extenders, which are usually included with the annual doc fix legislation. Three provisions in particular are crucial and should be made permanent along with permanent SGR repeal legislation.

First, the Qualifying Individual, QI, Program pays Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the federal poverty line. Most Medicare beneficiaries pay a monthly Part B premium of $104.90 and out-of-pocket costs that low-income QI recipients cannot afford.

Second, the Medicare therapy caps exception process allows access to needed care for people with long-term chronic conditions, most notably for those who require long-term therapy services.

Third, funding for critical community-based resources is also expiring. This includes outreach and enrollment assistance to low-income Medicare beneficiaries, as well as funding aging and disability resource centers. AARP will not consider SGR repeal legislation complete unless those beneficiary protections are included.

However, a question still remains on the need for budget offsets. In light of current and future savings in the Medicare program, Congress would be justified in not fully offsetting the costs of a permanent repeal at this time.

As the committee considers legislation, it is important to remember that half of all Medicare beneficiaries live on an income of less than $23,500 per year and spend 17 percent of their income on health care. Additionally, standard beneficiary premiums are established to cover 25 percent of Part B spending. Given this, one-quarter of any increase in Medicare Part B spending over current law will automatically be borne by beneficiaries in the form of higher

premiums. The typical Medicare beneficiary cannot afford to pay more out of pocket.

AARP has long advocated for responsible solutions for slowing Medicare spending growth and improving the program. Other system reforms recommended by AARP to help reduce Medicare spending, not part of H.R. 4015, include expanding competitive bidding for durable medical equipment, equalizing payments based on physician site of service, recouping overpayments to Medicare Advantage plans, increasing support for transitional care and chronic care management, and ensuring full and effective use of all highly skilled clinicians.

In addition, while lawmakers have considered shifting cost to beneficiaries, there has been little talk of reforming one of the most expensive areas of health care, prescription drugs. AARP believes that any discussion of budget offsets for Medicare reimbursement reform should include savings from prescription drugs.

We urge you to give strong consideration to the following prescription drug proposals that could save at least $150 billion: provide the Medicare program rebates for drugs for those who are dually eligible; enable the Secretary of HHS to negotiate for lower prescription drug prices; reduce the exclusivity period for biologic drugs; prohibit pay-for-delay agreements; and stop risk evaluation and mitigation strategies from being used to block generic drug and biosimilar product development.

Again, thank you for holding this hearing and for making SGR and Medicare reimbursement a priority at the start of the 114th Congress. AARP welcomes the progress that has already been made and looks forward to working with you to get physician payment reform across the finish line.

I would be happy to answer any questions.

Mr. PITTS. Thank you for your testimony.

[The prepared statement of Mr. Schneidewind follows:]

TESTIMONY BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

"A Permanent Solution to the SGR: The Time is Now"

By Eric Schneidewind
AARP President-elect

January 22, 2015

2322 Rayburn House Office Building
Washington, DC

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Summary

Permanently repealing the sustainable growth rate formula will bring stability and predictability to health care providers and the Medicare beneficiaries they serve. Congress should also address "health extenders", particularly:

- The Qualifying Individual (QI) program
- The therapy caps exception process
- Funding for community-based resources

In addition to the reimbursement reforms in the tri-committee bill last Congress, other system reforms recommended by AARP to help reduce Medicare spending include:

- Accelerate and expand competitive bidding for durable medical equipment;
- Equalizing Medicare payments for physician services between hospital outpatient and office settings;
- Recoup overpayments to Medicare Advantage plans;
- Increase support for transitional care and chronic care management;
- Ensure full and effective use of all highly skilled clinicians.

Congress should give strong consideration to the following prescription drug proposals that could save at least $150 billion:

- Provide rebates for drugs provided to Medicare Part D low-income support beneficiaries who are dually eligible for Medicare and Medicaid;
- Enable the Secretary of Health and Human Services to negotiate for lower prescription drug prices;
- Reduce the exclusivity period for biologic drugs;
- Prohibit pay-for-delay agreements between brand-name pharmaceutical maker and generic manufacturers;
- Stop Risk Evaluation and Mitigation Strategies (REMS) from being used to block generic drug and biosimilar product development.

Statement

Chairman Upton, Ranking Member Pallone, Chairman Pitts, Ranking Member Green, and members of the Committee, thank you for holding this hearing on reforming Medicare physician reimbursement, and for inviting AARP to speak from the Medicare beneficiary's perspective. My name is Eric Schneidewind, and I am the AARP President-elect. AARP is a non-partisan organization of over 38 million members ages 50+, many of whom are Medicare beneficiaries.

For over a decade, millions of Medicare beneficiaries have heard annual warnings that their health care provider would stop seeing them if the schedule payment cuts due to the sustainable growth rate occur. While Congress has intervened each time to prevent the cuts, Medicare beneficiaries remain fearful of losing access to their doctor. Thanks to the tireless work of many of the legislators and staff here today, we are closer than we've ever been to finally replacing this broken reimbursement system.

During the previous Congress, AARP was pleased to work with Committee staff from both chambers and both parties in developing what became H.R. 4015. Permanently repealing the sustainable growth rate formula will bring stability and predictability to health care providers and the Medicare beneficiaries they serve. Moreover, the reimbursement reforms in the bicameral bill are a significant step toward improving quality and value in Medicare. We applaud the move toward more coordinated care; the streamlined quality reporting system; the greater use of quality measurement; and greater data transparency, among other improvements.

Specifically, we support the creation of the merit-based incentive payment system (MIPS). This system will consolidate quality reporting programs, while reimbursing providers for the quality of care they provide, not the volume of care. A robust set of quality measure will be necessary to effectively implement MIPS. We urge the Committee, though, to revise the measure development process established in the bill, and require that *all* new final, approved measures be endorsed by a consensus-based entity before inclusion in MIPS. This will ensure that quality measures are based on standard definitions and are compatible with one another, and within the larger health system. This will limit confusion, as well as build support and create buy-in from stakeholders, including beneficiaries.

We also support encouraging participation in alternative payment models (APM). While some health care providers may always need to operate within a fee-for-service system, alternative models, such as shared savings or bundled payments, should be encouraged. Incentivizing the adoption of APMs is necessary to spur the shift away from fee-for-service.

Additionally, we support expanding claims data availability to improve care. In particular, we support allowing Qualified Entities to share analyses and information more broadly. Expanding the availability of beneficiary-protected Medicare claims data will provide valuable insights into the quality, value, and outcomes of medical care. These insights can lead to a range of benefits, including creating better comparison-shopping tools, to helping providers pursue quality improvement and patient safety initiatives and enabling payers and providers to work together to build higher-performing networks.

However, the final bill introduced last Congress did not include important "health extenders" which are usually included with the annual "doc fix" legislation. Three provisions in particular are crucial to ensuring beneficiaries have access to needed care and services, and should be made permanent along with permanent SGR repeal legislation.

First, the Qualifying Individual (QI) Program pays Part B premiums for beneficiaries with incomes between 120 percent and 135 percent of the Federal Poverty Line - about $14,000 to $15,750 - and less than $7,160 in assets for an individual. Most Medicare beneficiaries pay a monthly Part B premium of $104.90, an out-of-pocket cost that low-income QI recipients cannot afford. This program has consistently been extended for periods in concert with SGR extensions. We urge the Committee to make the QI program permanent as part of SGR reform legislation. Failure to make the program permanent would seriously threaten vulnerable Medicare beneficiaries' economic security and access to health care.

Second, Medicare therapy caps serve as a significant barrier to accessing needed care for people with long-term, chronic conditions, most notably for those who require long-term therapy services. Today, Medicare coverage for outpatient therapy services -- including physical, speech-language pathology, and occupational care -- is limited through arbitrary per-beneficiary payment caps imposed by the Budget Control Act of 1997. In 2005, Congress developed an exceptions process that allows people with Medicare to receive Medicare-covered therapy services above the cap when medically necessary. We urge Congress to repeal the Medicare therapy caps as part of an SGR reform package to

ensure access to needed care for older adults and people with disabilities. In the absence of full repeal, we ask that Congress make the therapy cap exceptions process permanent.

Third, we support permanently extending funding for critical community-based resources that are also expiring. This includes outreach and enrollment assistance to low-income Medicare beneficiaries, including an estimated 2.3 million individuals eligible for the Medicare Part D Low-Income Subsidy who are not enrolled in the program. As well as Aging and Disability Resource Centers (ADRC), the "no-wrong door" network of long-term care services and supports information and referral services.

AARP will not consider SGR repeal legislation "complete" unless these beneficiary protections are included.

Even if the policy provisions are agreed upon, a question still remains on the need for budget offsets. In light of current and future savings in the Medicare program, Congress would be justified in not fully offsetting the costs of a permanent repeal at this time. Other bills are being discussed without offsets. SGR repeal is of equal or greater necessity, and should not be delayed due to budget rules.

As the Committee considers legislation, it is important to remember that half of all Medicare beneficiaries live on an income of less than $23,500 per year, and on average already spend 17 percent of their income on health care. Moreover, as recently as 2010, Medicare premiums and cost sharing consumed 26 percent of the average Social Security benefit. The typical Medicare beneficiary cannot afford to pay more out of pocket.

Additionally, standard beneficiary premiums are established to cover 25 percent of Part B spending. Given this, one quarter of any increase in Medicare Part B spending over current law, including physician pay updates like those proposed in H.R. 4015, will automatically be borne by beneficiaries in the form of higher premiums. Proposals to shift even more costs to Medicare beneficiaries are unfair, considering many older adults and people with disabilities have a limited income. Further, proposals to shift greater costs to seniors are an inequitable way to increase Medicare payments for providers.

AARP has long advocated for responsible solutions for slowing Medicare spending growth and improving the long-term fiscal health of the program, including delivery system reforms and program integrity efforts. The bicameral bill made substantial improvements in these areas, and represents significant structural change to the Medicare program. Other system reforms recommended by AARP to help reduce Medicare spending include:

- Accelerate and expand competitive bidding for durable medical equipment. Competitive bidding is already saving Medicare and beneficiaries billions of dollars. Additional categories, such as home oxygen, clinical lab services, and non-durable products, could save billions more.
- Equalize Medicare payments for physician services between hospital outpatient and office settings. Equalizing Medicare payments for similar physician visits regardless of setting could save about $9 billion over 10 years.
- Recoup overpayments to Medicare Advantage plans. "Up-coding", or inflating a patient's risk score to receive a higher risk-adjusted payment, have cost Medicare $70 billion over 5 years.

- Increase support for transitional care and chronic care management. Improved transitional care post hospital discharge will reduce costly readmissions.
- Ensure full and effective use of all highly skilled clinicians. Increasing the supply of and more effectively using the services of nurse practitioners, physicians' assistants, and physicians, could improve consumers' access to care and reduce Medicare spending.

In addition, while lawmakers have considered shifting costs to beneficiaries, there has been little talk of reforming one of the most expensive areas of health care: prescription drugs. AARP firmly believes any discussion of budget offsets for Medicare reimbursement reform should include savings from prescription drugs. We urge you to give strong consideration to the following prescription drug proposals that could save at least $150 billion – savings that would roughly offset the cost of the SGR fix:

- *Rebates* - AARP supports the Medicare Drug Savings Act requiring prescription drug manufacturers to provide rebates for drugs provided to Medicare Part D LIS beneficiaries who are dually eligible for Medicare and Medicaid. This legislation focuses on constructively reducing costs, and has been estimated to save $141 billion over the next ten years, without negatively impacting Medicare Part D benefits or shifting costs on to Medicare beneficiaries.
- *Secretarial Negotiation* - Currently, the Part D program relies upon negotiations conducted by individual prescription drug plan sponsors to obtain lower drug prices. AARP has consistently supported legislation that would enable the Secretary of Health and Human Services to use the bargaining power of Medicare's 49 million beneficiaries to further negotiate for lower prescription drug prices, which is

especially important where there are no generic alternatives or competition in the class from other brands.

- *Biologic Drugs* - AARP supports reducing the exclusivity period for biologic drugs. Biologic drugs are some of the most expensive drugs on the market, and they hold the promise of treating some of the most serious diseases—such as multiple sclerosis, rheumatoid arthritis, cancer and others—that often affect older populations. Were the exclusivity period reduced from twelve years to seven years, it could result in billions of dollars in savings not only for beneficiaries and the Medicare program, but for employers and other health care payers.
- *Pay-for-Delay Agreements* - AARP urges Congress to take action on the Preserve Access to Affordable Generics Act sponsored by Senators Klobuchar and Grassley last Congress. This bipartisan bill would make it presumptively illegal for brand-name drug manufacturers to use pay-for-delay agreements to keep less expensive generic equivalents off the market. The CBO expects that enacting this legislation would accelerate the availability of lower-priced generic drugs and generate over $4.7 billion in savings between fiscal years 2012 and 2021.[1]
- *Risk Evaluation and Mitigation Strategies (REMS)* - AARP also supports addressing the loophole in FDA required Risk Evaluation and Mitigation Strategies (REMS). Unfortunately, REMS are increasingly being used to block access to samples of reference products to halt generic drug and biosimilar product development. The CBO has scored a proposal to ensure appropriate use of REMS to protect patient safety while maintaining access to generic drugs and biosimilars as saving Medicare $753 million over ten years.

[1] Klobuchar: New Report Underscores Need for Legislation to Crack Down on Anti-Competitive Pay-for-Delay Deals, July 11, 2013, http://www.klobuchar.senate.gov/newsreleases_detail.cfm?id=345314&

Again, thank you for holding this hearing and for making SGR and Medicare reimbursement a priority at the start of the 114th Congress. SGR reform will bring stability to Medicare provider payments and help ensure beneficiary access to care. AARP welcomes the progress that has already been made and looks forward to working with you to get physician payment reform across the finish line. I am happy to answer any questions.

Mr. PITTS. Time has expired on the vote. We have two votes on the floor, so members should go directly to the floor. Please come back immediately.

Thank you for your patience. The committee stands in recess.

[Recess.]

Mr. GUTHRIE [presiding]. Thank you. We will bring the committee back to order. Thanks for your patience during our voting time. I guess we will have until 12:30 until the next set of votes, so hopefully we can get through the questions. And I will recognize myself for questioning.

Yesterday we had a first panel in the subcommittee, and we heard from members of both sides of the aisle who said that SGR reform must be paid for. Former Senator Joe Lieberman warned that stakeholders who are pushing for unpaid SGR reform bill could actually sink the chances of getting a permanent fix adopted by Congress. We also heard from policy experts that there are bipartisan improvements to Medicare which can help pay for SGR reform.

So I want to ask the panel, everybody, to answer to this question. So I would be curious in hearing very briefly from each of our witnesses the answer to this question: Would you rather see a permanent SGR fix pass in March with bipartisan pay-fors or see Congress be forced to do another patch? So pay-for or patch? The option really isn't a question to say, well, an unpaid-for fix. It is a paid-for fix or a patch. And let's go briefly down the line of witnesses.

Dr. UMBDENSTOCK. Well, at the AHA, we would pick door number one. We think it needs to be fixed, frankly, should have been fixed a long time ago when the costs were lower, the problem was smaller. We put it off. At the moment, the rate of increase is so low that the projections are much lower as to the costs going forward. We think it should be taken care of, but I have to understand score again, not at the expense of payments to other providers.

Mr. GUTHRIE. OK. Thanks.

Dr. UMBDENSTOCK. We have got to find other solutions.

Mr. GUTHRIE. I am going to try to get down the list.

Dr. O'Shea.

Dr. O'SHEA. As I said before, we know that it is not just for physicians to say, but we do know that offsetting needs to be done for a permanent solution. So we are actually for a permanent solution and not for a patch. A physician is never going to want a patch.

Mr. GUTHRIE. Thanks.

Dr. Speir.

Dr. SPEIR. Permanent fix.

Mr. GUTHRIE. Permanent fix.

Dr. Miller.

Mr. MILLER. Permanent fix. We go with door one because the patch hasn't worked for so many years. We need to fix it.

Mr. GUTHRIE. OK. Thanks.

Dr. McAneny.

Dr. MCANENY. We also want a permanent fix to this. We are so close. You have developed great policy. If we can get the SGR out of the way, then we can move forward towards the more important

work of trying to restructure how we actually deliver care to our patients.

Mr. GUTHRIE. Thank you.

Mr. Schneidewind.

Mr. SCHNEIDEWIND. AARP would support a permanent fix, and we have proposed means to pay for it.

Mr. GUTHRIE. OK. Thank you. Thank you very much.

For Mr. Umbdenstock from AHA, in your testimony you wrote down four different ideas you said for cutting funding. You expressed opposition to cutting funding for services provided by other caregivers, which you just reinforced, and I understand, and you suggested there is a tipping point of the repeated ratcheting down of payments for Medicare and Medicaid hospital services past which patients on these programs will face harder times or they will have longer wait times if we continue to go down.

Could you just describe for the committee the scope of the cuts the hospitals have seen since 2010 and what type of cuts in the way of market basket adjustments are on the horizon? The situation the hospitals have been in since 2010.

Dr. UMBDENSTOCK. Be happy to. Thank you.

Since 2010, hospitals have experienced $121 billion in the 10 years after each of those cuts, $121 billion cumulative in cuts through the Medicare program, whether it was through sequestration cuts or cuts through coding offsets or reductions in bad debt payments under Medicare. A variety of different cuts have occurred totaling $121 billion.

In addition, there are payment reductions in the ACA that were agreed to, to help pay for coverage under the ACA. Those cuts are now starting to kick in as well. They were not in the first couple of years. They started essentially just before coverage started and now will roll out in the later years. So market basket adjustments, reductions in DSH payments, disproportionate share payments, and so on are almost looming. So additional cuts on top of that would be untenable.

Mr. GUTHRIE. You had several policy proposals when you did your testimony. Which ones that you brought forth would you suggest should be paired with SGR reform?

Dr. UMBDENSTOCK. Well, those are four that we wanted to highlight, in particular the combining of Parts A and B and the restructuring of that outdated method under Medicare; modifying the first-dollar coverage in Medigap policies to make more prudent buyers within the Medicare program; and increase income-related premiums, med mal reform; and I didn't mention, but always on our list is administrative simplification and regulatory relief.

So we think that those have all been scored. They have all received bipartisan support and should be considered as pay-fors.

Mr. GUTHRIE. Thank you.

And I will yield back 5 seconds because we are going to try to get everybody in before the next round of votes, if we can stick to the 5-minutes rule as close as we can.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

And I talked to some of you beforehand. All of us want to repeal the SGR. It is the issue of paying for it and how do we pay for it.

I don't want to put it on the backs of the Medicare patients. And some of you know the kind of district I represent. It is a very urban area. We have a great medical center in Houston. Although I have a very urban area, and the physicians who practice in my area are the ones 45 percent or 55 percent of their practice is senior citizens with Medicare. If we don't fix the SGR, they can't be in business.

Now, my suburban physicians can because they have a lot of third-party coverage, whereas if with you have a load of seniors on Medicare, you can't. So that is why I want to fix it, because I want those doctors to still be in my district so people don't have to go to the suburbs to see a physician. But that is the problem with paying for it.

Dr. McAneny, I understand the cost of a permanent repeal of SGR is $118.9 billion. I think that is the cheapest number I have seen since we have had it. It would cost $32 billion just to fix it for 2 years. And one of our concerns is, and I have heard all your and read all your testimony, is that how do we do it without impacting the patients who are part of Medicare, because, as we know, seniors on Medicare pay a huge percentage higher for health care, even though they have Medicare, than seniors under 65.

And so that is our concern. Are there any suggestions? I know there are some reforms we can do, and the reforms may be good in idea, but if they save money, then we can use that as a pay-for.

Dr. MCANENY. The AMA has a large body of Medicare reform policy which we have carefully thought of over many years and would love to have the opportunity to go over. With any pay-for, the question really will be in the detail. We feel that any solution is going to have to be bipartisan. It is going to have to be something that is bicameral and can be signed by the President. And we really look a lot to the leadership of this committee and Congress to lay the guidelines, and then we would be happy to work with you any way we can to try to look over the ideas that are presented.

We do believe that by getting the SGR out of the way and letting physicians restructure their practices, that we can do a lot to save money going forward. In my own practice, we have an Innovation Center grant that has created an oncology medical home. We have cut hospitalizations for cancer patients by almost half. That saves money and it takes better care of our patients. So we think there are a lot of things out there that can really provide better care with lower costs and that that should be considered as part of the equation.

Mr. GREEN. Thank you.

Dr. Schneidewind, I know representing AARP, and your constituents are actually the Medicare recipients. Do you know if any of the health reforms that you have seen or heard today that would actually save enough money we could use it for a pay-for, but would also have more efficient delivery to your constituents, AARP members?

Mr. SCHNEIDEWIND. Well, I think embedded in the legislation itself, of course, are reimbursement reforms which are going to produce that result. And I think what we look to is reforms that impact, for instance, competitive bidding for durable medical equipment. In one 5-year period there were $70 billion of overpayments

to Medicare Advantage plans, we believe for upcoding and that sort of thing. So that would offer $140 billion over a 10-year period. Transitional care, we could support that better, and that obviously reduces readmission rates.

But really the place to look for the savings, we think, are the drug costs, and steps like extending the rebates from just Medicaid to dual eligibles, you are talking about $140 billion over a 10-year period from that one alone. So we really respectfully suggest that this committee look hard at prescription drug costs as a place to save money, to leave these providers in a good position, and to make this Medicare program solvent and sound for the future.

Mr. GREEN. And I appreciate that because, again, in a district like I have, we have a lot of dual eligibles already. But that is the issue.

And, Mr. Chairman, I will yield back my 17 seconds.

Mr. GUTHRIE. Thank you. Being efficient. Trying to get the votes.

The next is also from Texas, Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Vice Chair. I appreciate you not referring to me as the old vice chair.

In the interest of time, I would like to actually pose a multipart question, or two questions, and then I would like to go down the line, starting with Rich and ending up at the AARP. And the two questions would be, as you understand the policy language of the 4015 in the previous Congress, are you supportive of that policy? And the second part to that question, would you support the committee making this a priority for this Congress? And not to lead the witnesses, but the correct answers are yes and yes.

Dr. UMBDENSTOCK. Thank you for that clarification. Yes and yes.

Dr. O'SHEA. Dr. Burgess, number one, we really want to thank you for all the work that you have done, we appreciate it, as the physician leader that you are.

Yes and yes.

Dr. SPEIR. Thank you, Dr. Burgess. Yes and yes.

Mr. MILLER. Thank you, Dr. Burgess. Yes and yes.

Dr. MCANENY. To be redundant, thank you, Dr. Burgess. Yes and yes.

Mr. SCHNEIDEWIND. Yes and yes. Thank you, Dr. Burgess.

Mr. BURGESS. Great. I am glad we all got that on the record.

Dr. McAneny, I need to ask you a question. I may have to move to get to a right microphone.

We have talked about the SGR for a long time. I have had a bill every term I have been in Congress. But a lot of people don't really understand what happens if we blow through a deadline, which we did at the end of 2005 when Republicans were in charge and we did three times in 2010 when the Democrats were in charge. Can you kind of trace out for us what the effect is on a physician's practice and a patient's access to their physician when we blow through those deadlines and why it is so critical that we not face those deadlines year in and year out?

Dr. MCANENY. Thank you, Dr. Burgess, for that question.

I do manage my practice in Albuquerque and in little towns in New Mexico where we serve a lot of underserved people. What happens when we blow through one of those deadlines is that we suddenly cannot submit a bill. Our cash flow drops very quickly be-

cause not only do I have to make pay payroll every 2 weeks because my employees live on that, they have to pay their mortgages and buy food, but I cannot buy the supplies that I need to treat my patients. I cannot afford to purchase the chemotherapy to give to the patients who are in need of it.

Then we incur double damage in that when we submit a bill and then there is a patch or a change that occurs later, then we have to resubmit the bill. The accounting nightmares are terrible to try to figure out what has actually been paid, what still is owed. I often have had to take out bank loans or lines of credit, which means that we lose the interest on that. And I am a small business, we have 200 employees, and a lot of people depend on us for their livelihoods. So this really is a devastating idea.

And as we are trying to restructure what we do to provide better health care, the uncertainty of not knowing whether or not my major payer, Medicare, is going to be there, is going to cut my fees by 21 percent, or whether they are going to reinstitute a zero percent, which is actually a 3 percent loss because the expense goes up about 3 percent per year, I haven't been able to give my nurses and my staff a raise for the last 2 years.

So it is devastating to us as small businesses. It is devastating to us as physicians because we can't do what we were trained to do, which is to take care of the people who depend on us.

Mr. BURGESS. Well, and the reason I asked that question, of course, we have until March 31 for something to happen, which is get the President to sign the SGR fix or come up with a doc fix for whatever period of time, and I am concerned that if we spend too much time reinventing the wheel now we will burn through that daylight that is available to us and push up against the deadline.

But let me just ask you as a practical matter, and perhaps, Dr. O'Shea, you as well, are you talking with your constituencies, your doctors who are part of your association, about the possibility that the full SGR cut might happen, that if Congress couldn't get its work done, that you might face this funding cliff that is set out in the statute?

Dr. MCANENY. Dr. Burgess, I think every physician, particularly those who manage a practice, considers that at about 3 in the morning, on a lot of mornings, of how am I going to keep the practice going if this happens. Yes, I think most physicians are aware that this would be devastating, and I think that more and more patients are becoming aware of what it would do to us if they couldn't get in to see their doctor at the time when they need their doctor.

Mr. BURGESS. Thank you.

Dr. O'SHEA. And I might say just, Dr. Burgess, say the same thing.

Mr. GUTHRIE. Well, the time has expired. We are trying to get everybody's questions before the next vote. So I appreciate that.

Ms. Matsui from California is recognized.

Ms. MATSUI. Thank you so much, Mr. Chairman.

First of all, thank you very much for being here. Appreciate your testimony. It is a very important issue. And I know how much SGR repeal and replace means to each of your organizations.

I have a huge healthcare sector in my district, four major hospital systems. I think Dr. O'Shea knows because you are a member

of one of them essentially. But I think that we have to do this. The thing is, the pay-for is so difficult. Where we stand now is seeing how to figure that out, and what I am hearing a lot about today is we want to do this but we don't want to do it here or here or here. And I am not singling anyone out, but that is the way it is here. But what I am looking at is let's do this but not at the expense of the seniors. Now, I think each of us feel that way too and are trying to balance that out.

So what I am looking at now is, let's be very specific, so some of these are questions I am hearing, currently Medicare beneficiaries have separate cost-sharing structures, when they see doctors versus when they go to the hospitals. There may be ways to simplify this and modernize Medicare benefits to look more like health insurance products we see today. But current proposals to redesign Medicare benefits such as combining Part A and B deductibles would redistribute the burden of healthcare costs to the most vulnerable in the program.

So, Mr. Schneidewind, can you talk about the potential impact on beneficiaries of a combined Part A and B deductible?

Mr. SCHNEIDEWIND. Yes, Representative. The Part A deductible is significantly higher than the Part B deductible, and so if those two are combined into one average number, it is pretty clear that a senior going for medical services as opposed to hospital would end up paying a higher deductible than they had prior to the change.

And what concerns us is that in that situation somebody who is using medical services a lot and hospital very little would effectively, number one, be penalized financially and have a disincentive to seek care from physicians. And I hope people will recognize that the average person who is receiving Medicare has an income of $23,500, half have less than that, they pay $4,000 out of that $23,500 for medical care already. So increasing that, in addition to the regular Part B increases that occur, is unaffordable.

Ms. MATSUI. OK. Thank you.

Now, these new payment delivery models incentivize and the SGR repeal and replace policy can make Medicare services more effective and maybe more efficient. This will save money while improving care. However, these savings are often difficult to demonstrate and quantify, as they occur in long-term time windows, we know how difficult it is to even score those things, and involve savings to the overall health system, not to mention the improvement in quality care that can be an invaluable effect on a patient's life. You can measure and estimate the reduced hospitalization costs caused by better management of a senior's chronic conditions, but you can't put a price on how that impacts seniors and their caregivers' lives. So I believe a more holistic approach to patient care, including strong preventive care, saves costs and lives.

So, Dr. O'Shea, please discuss the benefits of the holistic approach to care, and include any comments you may have about savings that can be achieved and how this fits into what we are trying to do today, because I think we have to apply a holistic approach to this SGR replace-and-repeal policy too.

Dr. O'SHEA. I appreciate the question.

Taking a holistic approach is what I think we have been gearing up for, for many, many years here. So what I would be speaking of is implementations the greater part of physicians around the country have done is with an her. The her and the patient-centered medical home are just ready to do these things, taking the whole patient into consideration. I actually lead the diabetic program at Sutter Amador Hospital.

Mr. COLLINS. Could you speak into the microphone?

Dr. O'SHEA. As doing that, and as working with the chronic care model, when you have more implementation of preventative services early on in the chronic care model, you are going to get larger savings, you are stopping the fast creep of a chronic and a high-cost patient into a much more controlled, extending the care in an ambulatory setting and not having to use the hospital setting.

We can do that, and I would speak also for combining Part A and B, if that can be achieved, but doing that and making sure that the primary care home that is specific for the patient, because it has to meet patient needs, is implemented, and in doing that in an aggregated affront to these costs, making the patient, but also the physician, accountable and knowing with all the information that we now can look at ourselves and look at your own cost savings, making those numbers known to physicians, to physician societies, to different state societies. You know, looking and then comparing to one another. I think as physicians we are used to being compared in services and things like that. You will actually find that we can tolerate that, can get geared toward that a lot faster than just always rotating patients.

Ms. MATSUI. OK. Well, thank you very much.

Mr. GUTHRIE. Thank you. The gentlelady's time has expired.

The chair is going to recognize for unanimous consent a standard of care statement that has been offered by the Cooperative of American Physicians, NORCAL Mutual Insurance Company, PIAA, Texas Medical Liability Trust, The Doctors Company. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. The chair now recognizes Chairman Barton.

Mr. BARTON. Thank you, Mr. Chairman. It is good to see you in the chair. It is good to see Mr. Green as the ranking member of the Health Subcommittee. That is quite an honor. It is good to have you there.

I haven't watched this on TV, nor have I read your testimony. So I am a total innocent. But I will make a bet right now that we have agreement that we need to fix the SGR, everybody has said that, but I bet not one of the panelists has offered a way to pay for it. Am I right or wrong?

What? We had somebody offer a pay-for?

Dr. UMBDENSTOCK. I think the American Hospital Association put forward suggestions, as did——

Mr. SCHNEIDEWIND. As did AARP.

Mr. BARTON. Well, I would have lost that bet. You all should have taken me up on it. I would have bought everybody a free Dr. Pepper down in my office.

Well, good for you. I was going to offer a proposed solution that the people that didn't testify had to pay for it, since you all weren't willing to pay for it.

So do we have an agreement that there should be a pay-for? Is there anybody that opposes that?

Mr. SCHNEIDEWIND. We have raised the possibility that, given the reforms, there may not need to be, but out of respect for your desire for some information, we have proposed pay-fors.

Mr. BARTON. Then the second part of is there a pay-for, I am going to ask the chairman if as a committee do we have a position that the pay-for should come out of the medical system or are we looking at pay-fors outside the medical system?

Mr. GUTHRIE. From what I understand, we are still looking at pay-fors. There has been no overall——

Mr. BARTON. Within the medical——

Mr. GUTHRIE. I think we are looking at all pay-fors, all opportunities for pay-fors.

Mr. BARTON. OK. Because if we were willing to look outside the system we could do some oil and gas revenue royalties from the OCS or Alaska or federal lands. I have an Internet poker bill that would probably generate $50 billion over 10 years.

Mr. GREEN. If the gentleman would yield.

Mr. BARTON. I would be happy to.

Mr. GREEN. Our side, we don't mind looking outside health care, but I have to admit, I can't sign on to your Internet poker bill.

Mr. BARTON. That would be theeasiest pay-for because the poker players of America would willingly pay that surcharge to be able to play poker on the Internet. And that was seriously looked at in the last Congress, actually. I mean, it is enough money that it is real.

Well, I want to commend Dr. Burgess for the work that he has done over the last several years. He has been absolutely committed to fixing the problem. And as you all know, this last Congress we actually passed an SGR fix but we didn't have a pay-for and it foundered.

I think Chairman Upton and Subcommittee Chairman Pitts are committed to going all the way this session with a real pay-for that solves the problem, and I will be a part of it, of the system at that point in time.

With that, Mr. Chairman, I will yield to any other member who wishes my time.

Dr. Burgess.

Mr. BURGESS. If the gentleman will yield for clarification. The bill that passed the floor of the House the middle of March of 2014 was paid for, was offset. The offset came from the Affordable Care Act. And for people who disagree with that strategy, I would simply offer that if you were going to reform health care in this country from soup to nuts, you ought to start by fixing the SGR. So that was a logical place to go. I am sorry people didn't agree with that over on the Senate side. I am willing to look at other pay-fors. But our bill was offset when it passed the floor of the House last March. And I yield back to the gentleman.

Mr. BARTON. I guess I will ask one more question. Does the panel think there are enough savings in Medicaid if we gave more flexi-

bility to the States? All the State Governors and Medicaid directors are always asking us to give them more flexibility. Is that a potential pay-for that you all might be willing to work with us on?

Dr. UMBDENSTOCK. Well, from the hospital point of view, we find Medicaid to be a very stressed program already and are very concerned about further cuts to that program.

Mr. BARTON. So that is a no.

Dr. UMBDENSTOCK. For the record, if you decided to solve this problem without a pay-for, we would not object. Just for the record.

Mr. BARTON. Put me down as not surprised with that answer.

With that, Mr. Chairman, I yield back.

Mr. GUTHRIE. Thank you. The gentleman yields back.

Recognize Mr. Schrader from Oregon.

Mr. SCHRADER. Thank you, Mr. Chairman, appreciate it.

I appreciate the panel. I appreciate the panel for the most part coming up with ideas for us to pay for the SGR reforms, since it has such broad support to get this done and get the Sword of Damocles off the physician and hospital community's backs, and, frankly, the seniors, seniors' backs. They have been up against. I think every one of us has had horror stories of seniors not being able to find physicians or nurse practitioners to take care of them because of what we are doing or not doing here.

With that, just several questions. Dr. McAneny, maybe you could elaborate a little bit more on how the fee-for-service system is actually hurting or prohibiting——not prohibiting, but I think impairing physicians' and nurse practitioners' ability to provide the quality care that they think they can do. You alluded to that a little bit.

Dr. MCANENY. Thank you, Representative, for that question.

The fee-for-service system worked well before there was much that we could do in the outpatient arena. There were limited things we could. It was easy to enact fees for those. Currently, now, if we want to manage patients in a different way, if we want to have nurses or other staff members on the phone talking to patients, intervening early, helping people manage problems at home, we are not paid for that. And physician practices find that they have to generate enough of the billable codes to pay the infrastructure that it diverts our attention away from some of the changes that we could make to better deliver that care.

In addition, now with all the regulatory requirements that are there that are not paid for with trying to comply with Meaningful Use, PQRS, the value-based purchasing, et cetera, we are spending more and more time away from patients, away from anything that even generates a fee, and away from things that actually help us manage a patient. That is why we are so excited about this committee's proposed bill where you get rid of all that, consolidate it into one streamlined system so that we can take some of those resources, have the opportunity to try out systems that may include some fee-for-service but may include a lot of other options as well, and see if we can't design systems that will work in our individual practices to be able to deliver better patient care at a lower cost. So thank you.

Mr. SCHRADER. Very good.

Dr. Speir, maybe describe a little bit how comparative effectiveness research can improve care and provide, hopefully, physicians, particularly in the specialities, almost a safe haven in terms of liability and lawsuit issues.

Dr. SPEIR. Thank you, sir. I think that we have shown in our region that by looking at the STS database outcomes linked to the clinical cost with evidence-based guidelines, which is actually door number C that was not alluded to before, that we can dramatically decrease the cost and improve the outcomes.

And the pay-fors, as we discussed, while the focus has been off the top payments, we can continue to deliver such care which is reflective of what you had said, Congresswoman, and show the improvement in care while decreasing such cost. And I think that this is, to dovetail on your previous question regarding fee-for-service, that is a totally outcome-exclusive proposition that is only focused on volumes of patients, procedures performed or tests that are done.

Mr. SCHRADER. Right. Completely the wrong incentive.

Dr. SPEIR. That is correct.

Mr. SCHRADER. I come from Oregon and very much into outcome based, and a nice way to marry up to primary care with the specialty care, and I think the way you guys are doing it is just really exciting and going to happen regardless of what we do, I think, here in Congress, and I am just really pleased with that.

Last question, if I may, with Mr. Schneidewind. The biggest concern I think a lot of us have is foisting too much of the cost, if you will, on the beneficiaries, and we struggle with this. I have been involved in different work groups trying to figure out how can we minimize that impact. I don't think my seniors are afraid to pay a little bit more as long as everyone is paying something, but they want to make sure they get the quality care that they get at the end of the day.

Some of the proposals with the means testing or the combining premiums, you talked a little bit about the deductible issues that seniors face, what if there were exclusions or work with your group and others to make sure that the low-income folks below——pick a number, 200 percent of poverty level or whatever it might be——are excluded from some of these beneficiary cost-sharing ideas, would AARP be willing to work with us on something like that?

Mr. SCHNEIDEWIND. Well, one of the concerns that we have, and we have seen this in the proposals to income relate, for instance, premiums, that right now somebody at the top range is paying three times the premium as somebody at the bottom. And we worry that the more those premiums go up, for instance, the more incentive these people have to simply go off Part B and seek their insurance elsewhere, because right now those premiums are very high. And some of the proposals we see, for instance, really start kicking in at $85,000 of income, whereas the IRS considers a wealth person $400,000.

You are really starting to reach down and increase the cost of care for a lot of people. Right now, as I have said also, the people, let's say half of the people are at $23,000 of income, and they are already paying $4,000 of that in medical care, and they are paying premium increases as they occur, and they have incurred steadily.

So we think with the very promising savings that are available in the prescription drug arena, through some other reforms, looking at the payments, for instance, to, you know, upcoding on Medicare Advantage——

Mr. SCHRADER. OK. Very good. My time has expired. I will take that as a no, but thank you very much.

Mr. GUTHRIE. Thank you, Dr. Schrader.

Dr. Schrader's time has expired.

Mr. Lance of New Jersey is recognized.

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

I would have been surprised if anybody on the panel had not favored a permanent solution. And I have read the testimony, including the suggestions that have been made. In my own view, it will be very difficult to achieve this by March 31. And, for me, the question is, is there a method to pay for a permanent solution that can pass both houses of Congress, be signed into law by the President of the United States? I think that is an extremely difficult question to answer.

And I am also concerned by the fact that the deadline approaches and we have other fundamental issues regarding healthcare policy that we may have to address in this session, particularly if the Supreme Court rules, as it may very well rule, that there can be no subsidies to the Federal exchange.

Is there anybody on the panel who might be willing to address that potential as it relates to SGR?

Don't all volunteer at once. Anybody on the panel?

My point, obviously, is that these are great issues with moving parts, and they are not simply an issue that relates to SGR, although SGR is an important component of it.

Mr. Umbdenstock, some say that SGR reform is Medicare reform rather than simply a physician payment bill, and in your report, "Ensuring a Healthier Tomorrow," there have been a number of suggestions made. What was the catalyst for the report, and why do you think that Medicare reform is important, particularly in the context of SGR?

Dr. UMBDENSTOCK. Thank you very much, sir.

First of all, the catalyst for the report was an update of our view of what additional changes need to happen, and that was done 2 years after the passage of the Affordable Care Act.

Mr. LANCE. Yes.

Dr. UMBDENSTOCK. So we updated our reform principles and framework. And in there we stressed not only the various issues that we think need to be addressed, but this notion of shared responsibility, that providers and consumers and suppliers and government and private sector, we are all going to have to make changes in order to get this done.

Secondly, SGR is important. It is critical. It has been kicked down the road for too long. The uncertainty that comes with it for physicians and therefore for patients and access, we have just got to solve it. But it is not the sum total of Medicare reform. So we have to think about solving this problem in the context of how the solutions may also help us in the long-term reform of the program, and that is why we proposed some of the things that we did for your consideration.

Mr. LANCE. Thank you.

And to Dr. Speir, the Society of Thoracic Surgeons has a national database, and you have discussed that in your written testimony, and you have discussed the fact that it might be applied to the Medicare program at large. And if you would discuss with the committee your views on that and the positive outcomes that you have experienced in your field from an innovative use of data and implementation of this program.

Dr. SPEIR. Thank you. We feel very strongly that the registries are really applicable not only to procedurally based practitioners, but really to all physicians, and that the time is now for us to not only be accountable and begin to participate with such registries regardless of our specialization, but then use that data in the turnaround to improve our care and therefore reduce the cost.

It is not only for the Medicare patients, but anyone that undergoes cardiac surgery or any procedures, or pulmonary resections for esophageal resections or anything to do within our specialty. These registries and the concept of that have also been expanded in other fields, whether it is vascular surgery, neurosurgery, and more and more are getting on board with that. But that is our future, all of us.

Mr. LANCE. Thank you.

In conclusion, let me say I want to associate myself with the fine work of Dr. Burgess and also with the comments of Chairman Emeritus Barton. And I do think that we should look sincerely at Chairman Barton's suggestion regarding funding, perhaps to some extent from Internet poker. And the reason that this issue has not been resolved institutionally in Congress is that it is a very difficult issue, and we have panels come before us all the time saying a permanent solution is necessary. It is much more difficult to determine how to pay for it.

Thank you, Mr. Chairman.

Mr. GUTHRIE. The gentleman yields back.

Recognize Mr. Butterfield of North Carolina.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, and let me apologize for being late. I have been multitasking all morning long, as all of my colleagues do every day.

But thank you for coming, thank you to the six witnesses.

And thank you, Mr. Chairman, for convening this hearing.

I am encouraged by the hearing so that we can talk about the long-term concerns that are facing the Medicare program. My goal as just one single member of this subcommittee is to provide greater certainty for providers and beneficiaries, and I am happy, very happy, that there is a bipartisan agreement, as it appears, that is pursuing a permanent fix to the SGR as the most prudent way to go forward.

Since 2003, Congress has patched the formula, as we all know, 17 times at least, each time causing trepidation among providers and beneficiaries. Seniors in my district, including more low-income individuals and many African-American citizens, do not know if they will be able to see the same doctor next year. My providers do not know if they will be able to serve the same patients next year.

So we can, Mr. Chairman, and we must come together and find a long-term solution to this problem, and this bill is a step in the right direction. Mr. Chairman, we can fix this thing. The pay-for is obviously the problem, but I believe that if reasonable minds can come together and forget the partisanship, and I think if we sit together, we can figure this thing out and get a permanent fix to this problem.

I will make the observation that it cost $144 billion to fix it over a 10-year period, and that is, indeed, a lot of money, but we have to talk about budgeting in relative terms. We spent $10 billion per month in Iraq, and that is 14 months of conflict in Iraq versus a permanent fix for the SGR. Mr. Chairman, we can do this thing.

Let me ask my question to the president-elect of AARP. I cannot pronounce your name. I am from the rural South, and I dare not even try it. But, sir, we have heard a number of proposals that would reduce the Medicare benefit for those currently on the program or those even eligible for Medicare. For example, we have heard proposals from others on the other side of the aisle that would gradually raise the Medicare eligibility from 65 to 67. You know all about that.

This proposal is very concerning to me because I think that it is a little bit shortsighted. Its consequences are far-reaching. These people will still need coverage, and certainly they will get sick. I also believe this change would be breaking a longstanding intergenerational promise that we made to the American people.

Very quickly, can you speak to the effects of raising the Medicare eligibility age, at least on the members that you represent?

Mr. SCHNEIDEWIND. Well, our feeling is that it represents really a cost shift, not a cost savings, and let me describe that. By raising the eligibility rate, you end up having people on their Affordable Care Act insurance, if they have it, for a longer period of time or their private insurance. That means that the pools there have to pay for an older population because the age to transfer to Medicare is extended. So the costs go up, and those costs are borne by businesses, by governments, and by those who provide insurance to their employees. So it hurts the economy.

On the other hand, for Medicare, it ends up making the population in the pool older on average, because coverage starts at an older age, and that increases Medicare costs. So you have increased costs for Medicare, you have increased costs for private and ACA insurance, you have increased costs for employers who hire people, and, because those effects now are being looked at, my information is that the estimates of savings from this measure have been drastically reduced by the Government Accounting Office, because they have fully understood now what this would really do.

Mr. BUTTERFIELD. So the cost of raising it by 2 years is insignificant in the scheme of things?

Mr. SCHNEIDEWIND. Well, it has turned out to be a lot. The savings have turned out to be almost nonexistent when you look at Medicare, the private insurance market now, the ACA, and the fact that rather than eliminating costs, you are simply shifting the cost to different forms of insurance. So our information is that, yes, indeed, the estimates of the overall savings have shrunk drastically.

Mr. BUTTERFIELD. And that is the position of AARP?

Mr. SCHNEIDEWIND. Yes, that we oppose the raising of the Medicare eligibility rate, because it would make Medicare on average more expensive, because the risk pool is now older. It would shift costs to the current employers, government, businesses, and others, make their plight worse. And because of that, we don't see net savings, we just see shifting in cost.

Mr. BUTTERFIELD. Thank you. Sir.

I yield back, Mr. Chairman.

Mr. GUTHRIE. Thank you. Gentleman yields back.

Recognizes Ms. Brooks from Indiana.

Mrs. BROOKS. Thank you, Mr. Chairman.

This is to Mr. Umbdenstock. Did I get your name right?

Dr. UMBDENSTOCK. Yes. Thank you.

Mrs. BROOKS. Each year, and in my district of northern Indianapolis into the north, I hear from hospitals all the time, they dedicate so many resources and so many dollars to avoid the unintentional technical violations of the Stark Act. And it seems to me that these paperwork-type of violations, which often come from often minor violations, result in the hospital paying millions of dollars in Stark Law penalties.

And I was a cosponsor in the last Congress of the Boustany-Kind, the Stark Simplification Act, that would limit the penalty a hospital can pay, can suffer for committing a technical violation, create an expedited process with CMS. But I think, more importantly, industry officials have produced reports showing they could generate a billion dollars in new revenue if this type of law were to be passed. Not a savings, but in fact revenue.

Can you please comment on whether or not you agree with this? Does the AHA support the Stark Administrative Simplification Act in the last Congress, and do you believe that it will actually generate new revenue?

Dr. UMBDENSTOCK. Thank you very much for the question. And absolutely we are supportive and we appreciate your support of that bill. You are exactly right that hospitals are being tied up endlessly for situations that were unintentional, technical in nature, and had no adverse impact on the program or the beneficiaries. So we really want to see that type of relief instituted.

I have to say that I am not familiar, I am sorry, with studies that would show how this would increase revenue to the government. Maybe you could help me.

Mrs. BROOKS. If this bill were to be reintroduced, is AHA going to be supportive of Stark simplification?

Dr. UMBDENSTOCK. Indeed. Indeed. Yes. Thank you.

Mrs. BROOKS. And do you think it at least could be and maybe should be part of the discussion about a pay-for for SGR repeal? And how could they be connected?

Dr. UMBDENSTOCK. Certainly, if it would produce savings and simplify the work experience, the overhead costs, the unnecessary costs of compliance to the hospital field, we would definitely see that as a plus.

Mrs. BROOKS. To Dr. McAneny, I have appreciated the way in which you have given us some very concrete examples of how your patients are impacted, and I again want to also commend Dr. Burgess for his leadership on this issue.

Can you share with us a few more examples of how this bill would have the potential to help increase the quality and the services, delivery of care, to seniors and the disabled? How can we do a better job articulating to the general public how fixing the SGR will actually improve quality and delivery of care? You mentioned things of uncertainty in physicians' practices, but can we talk a little bit more specifically with respect to quality of care for patients?

Dr. MCANENY. Certainly, and I very much appreciate that question.

Right now there is a limited amount of money in any physician practice that we can spend on improving what we do, and all of that money is currently getting diverted now into trying to comply with Meaningful Use, trying to comply with PQRS, filling out all of the various insurance company requirements for quality measures, often quality measures that are not applicable to our specific specialty. And this bill, I think, is a good vehicle to do that, to consolidate that. We could then take that amount of money and start to look at alternative payment programs.

So to get very specific, in our practice and in the six other practices across the United States that are participating with us in creating the oncology medical home, what we have done is spend a lot more of those resources on teaching patients how to use the system, how to get help from us when they need it, what do they need, having pharmacy techs who can call up and re-explain what is going on with their medications, having nurses on the phone answering questions, having same-day visits and same-day appointments so that patients seek care at a lower cost side of service by physicians who know them rather than going to the emergency department who is set up to deal with car accidents and heart attacks and not really cancer patients.

So the point is that many physicians in various specialties have the ability to really designate things that will make a difference in their individual practice if we weren't busy trying to use all our time, money, and resources on complying with these other entities.

Mrs. BROOKS. Thank you.

And thank you all for saving lives. Appreciate it.

Mr. GUTHRIE. Gentlelady's time has expired.

We recognize Mr. Cardenas of California.

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

I have a question for Mr. Schneidewind. Some proposals suggest one option for raising more money for Medicare is additional income relating to the Medicare Part B premium. Aren't Medicare premiums already income related?

Mr. SCHNEIDEWIND. Well, yes, they are. In fact, they span, they are multiplied almost three times from the basic level if you are at the upper-income level of about $213,000. So that the truth of the matter is they are heavily income related, and we fear that if they are increased too much more people who are paying that may find other forms of insurance attractive and leave the Medicare pool. And that is a problem because studies have found that the upper-income group tends to be more healthy, and, frankly, they are making a contribution to Medicare economics, and if they leave the plan will be disadvantaged.

I guess the other thing is that proposals in terms of income relating are reaching down into levels of income that are hardly wealthy. I mean, IRS thinks that $400,000 of income is wealthy, and yet some of these proposals would reach down to people making $50,000, $40,000, and that is not wealthy.

Mr. CARDENAS. No, I would say it is not. It doesn't matter what part of the country you are in.

Part of your response referred to the income averaging of a program. In other words, how revenue comes in and where do you get that revenue, et cetera. And if certain components are actually pushed out of the system or are encouraged to leave the system, then that would cause some kind of imbalance to the entire system, correct?

Mr. SCHNEIDEWIND. Right. If you push out of the system people, number one, who are paying the most, by a factor of 3 right now, number two, tend to be healthier than average so they impose less cost on the system, what you have done is deal a blow to both the revenue and the cost adversely. You are raising costs and you are decreasing revenue. So we think that really at this point the income-relating features have gone about far enough, and if they go further, they will produce those undesirable effects.

Mr. CARDENAS. Now, on one side you referred to plan premium. In other words, how much somebodyis paying to have that plan in effect for them and/or their family. Yet at the same time, when somebodyis looking at a premium it doesn't necessarily mean that they are comparing apples to apples when it comes to what benefits they are getting for that other plan, correct?

Mr. SCHNEIDEWIND. Well, you mean——

Mr. CARDENAS. I mean, it is not inherent. For example, if somebody is paying X amount premium for coverage with Plan A, and then all of a sudden they are just looking at the premium mainly and they say, well, this premium is $10 less a month, I am going to go that, it doesn't necessarily mean that the person is getting equal coverage for less money. It could be that they are actually going to something that they don't realize until later, maybe after being it for a year or two or what have you and saying, wait a minute, I am talking to my friend Edna who lives next door, she stayed on Medicare, I went to this other plan, and she, as it plays out, I might be saving a few bucks a month, but at the same time the overall plan, she is actually getting more benefit.

Mr. SCHNEIDEWIND. That is correct. And I think AARP very strongly believes that it pays to be a smart shopper, that what we have seen is that there is a rapid annual shift in premiums, even the same plan. So we advise our members and try to help them seek out the most advantageous plans and compare apples to apples, as you have said.

Mr. CARDENAS. Well, I think it is important for us to understand that, especially the lower-income Americans, what have you, although they might be very smart or what have you, but might be making decisions without being very well informed. Yet at the same time when it comes to the plan layout as it is today, there was a lot of thought and calculus going into that already, correct? At least on the end of putting these plans out there.

Mr. SCHNEIDEWIND. Well, sticking just to Medicare, of course, you know, that is a uniform benefit, although there are chances to go to Medicare Advantage. You have that choice. If you go to a traditional Medicare there are certainly a lot of supplements out there. Customers have proven very capable of choosing among those. And as I said, AARP certainly has tried to make and help our members be wise purchasers.

Mr. CARDENAS. Yeah. I would like to commend AARP, because when they showed me how involved they were in this new paradigm shift, that they were actually one of the best Web sites I had seen out there, and they were doing it on their own volition. And I think it not only educated seniors, but it educated family members beyond that. I know that when my parents were around, us kids always got involved in these decision processes. So it was a learning experience not only for them every time we did that, but it was something we took with us. And now that I have my own family, I am glad that that opportunity took place.

Thank you very much, Mr. Chairman. I yield back my time.

Mr. GUTHRIE. Thank you. The gentleman's time has expired.

The chair recognizes Mr. Collins from New York.

Mr. COLLINS. Thank you, Mr. Chairman. If we could ask the witnesses to kind of speak right into the microphone to hear you. I mean, it is almost impossible.

First of all, my question is going to be directed at Dr. McAneny and Mr. Umbdenstock. But first I want to thank Mr. Schneidewind for your comment on the age 67 cost shifting. It is a very poignant point.

Mr. GUTHRIE. Mr. Collins, is your microphone on? I request that you speak into the microphone.

Mr. COLLINS. I am speaking into it, but it wasn't on. I guess Ms. Brooks turned it off.

But I also have a request. Can you take my wife's name off your mailing list? She doesn't want to be reminded she is 50 years old. So if you could do that, I would appreciate it.

Mr. SCHNEIDEWIND. I will do my best.

Mr. COLLINS. My comment really is on the defensive medicine side and the need for medical insurance liability reform, which the CBO says could pay for half of this SGR fix, but also save a lot of money in other areas beyond Medicare.

If I could ask, Dr. McAneny, maybe spend 2 minutes on that or a little less, and then shift it over to Mr. Umbdenstock, how the defensive medicine piece plays in. And I have heard numbers it can be as much as 20 percent of our medical costs, running tests and the like that really aren't necessary. But defensive medicine against lawsuits.

Dr. O'SHEA. Dr. O'Shea will answer your question.

I come from California. In California we have MICRA. MICRA is a gift. MICRA is a gift to physicians. MICRA contains our medical malpractice insurance. I always tell my patients I am glad that I have medical malpractice, I am human, if I make a mistake, I really want you to be able to garner the best benefits for it. But that doesn't mean outrageous fees for the pain and suffering that mostly don't go to the patient either.

When you have contained costs this way, it lowers the overhead. And private practitioners will tell you we live on a margin. I know some of my OB-GYN colleagues, including my husband who is an OB-GYN, can work 4 to 5 months out of the year just to pay for their medical malpractice. Where does that leave a private practice to do any kind of innovation, to do any other kind of cost savings in their medical home, develop other systems to try and innovate for their patients, when you are your own practice? Medical malpractice is a big issue that is not going to go away. We do want to have it, but we want to have it where it actually benefits the patient and maybe not someone else.

Dr. UMBDENSTOCK. Thank you, sir, for the question, and I would agree with the sentiments just expressed. Yes, it is a big issue. Our costs in that area continue to rise. But as you point out, it does encourage defensive medicine. That only exposes patients to more interventions, for more potential for things to go sideways or not well. The estimates I have heard are similar to what you say, about 20 percent, one in five decisions some physicians tell me.

I think we need to think about a more expeditious approach, to Dr. O'Shea's last comment, that really does help the aggrieved patient quicker, more simply, more respectfully, something that encourages the practitioner and provider organization to come forward and acknowledge if something has gone wrong, an open apology to the family, work together, but look for more of an administrative approach, and the AHA can provide ideas on how to do that.

Mr. COLLINS. Thank you.

One last word, then, from Mr. McAneny.

Dr. MCANENY. Yes. Thank you very much.

TheAMA has extensive policy on the effects of professional liability on the ability to deliver care. It is at best a diversion from the things that we want to be able to do.

If we were able to, again, redirect all of the efforts that are made towards triple checking and quadruple checking ourselves by getting more and more testing in order to be able to cover ourselves I think we would be able to divert a lot of that money into things that would be better care for patients. So the AMA is happy to work with the committee on trying to look at what the effects of professional liability reform would be.

Mr. COLLINS. Real quickly, we have 30 seconds, could I just ask each of you, do you agree that the need for medical malpractice reform is right at the top of the list?

Dr. UMBDENSTOCK. Yes.

Dr. MCANENY. Yes.

Mr. MILLER. Absolutely.

Dr. SPEIR. Yes.

Mr. SCHNEIDEWIND. I am not sure that that would be at the top of our list.

Mr. COLLINS. But it is important.

Mr. SCHNEIDEWIND. It may be important. I haven't prepared a detailed answer on that, but we will look at it.

Mr. COLLINS. Yeah. Very good. Thank you all very much for your participation.

Yield back, Mr. Chairman, 5 seconds.

Mr. GUTHRIE. Thank you. I appreciate the gentleman for yielding back.

The ranking member of the full committee is recognized for 5 minutes.

Mr. PALLONE. I am sorry, Mr. Chairman, I didn't realize who you were talking about. But that is okay. I guess it takes a while.

I wanted to ask Mr. Schneidewind, hope I am pronouncing it properly, I am concerned that some would tie the SGR to other poison pills that would cut access to care or increase costs on beneficiaries. And seniors already bear significant out-of-pocket costs in Medicare, and most are living on very modest incomes. In fact, half of all Medicare beneficiaries have incomes below $23,500. You have heard that figure.

Can you talk a little about a typical income of Medicare beneficiaries and the out-of-pocket costs, you know, premiums, deductibles, other cost-sharing burdens that beneficiaries already bear as a share of their income.

Mr. SCHNEIDEWIND. First of all, the $23,500 income and 17 percent of that income is spent on medical care, that is $4,000 out of $23,500. I mean, that is huge already. It represents about 25 percent of the average Social Security benefit that these people get. Once again, huge amounts.

Now, these people already pay a Part B premium of about $105 roughly per month, and then on top of that they pay their deductibles and copays, and some of them may end up buying, if they have standard or traditional Medicare, may end up buying supplemental coverage as well.

So you can see that not only in percentage of income, but they have seen increases. They fully participate, for instance, every time Medicare Part B premiums go up, as they do and as they have, the people who buy that coverage are participating in paying for those increases.

So we believe that the burden on, particularly, lower-income people, but all people, is very significant, and AARP really believes that, if there are savings to be made, if there are offsets to be made, that we need to look at economies and prescription drugs in terms of payment reforms, such as are contained in this legislation, and other things, such as competitive bidding for durable medical equipment and things like that.

Mr. PALLONE. And then, I mean——yeah. I am kind of putting words into your mouth.

But when costs are too high, I assume a lot of beneficiaries in some cases just forego care. And do you want to just talk about the consequences of that briefly.

Mr. SCHNEIDEWIND. Yes. You know, that is a particular concern of ours when discussion is had about increasing co-pays or deductibles.

The downside of that is that people then are reluctant to go in and see their healthcare provider, whether it is a hospital or a doctor, and they may not get the care they need.

And then, of course, down the road, it may be that they have a condition that worsens drastically for lack of a modest amount of care and then becomes a burden on the entire system.

So we really believe that many of the proposals to increase deductibles and co-pays will produce higher costs for the system and have adverse consequences. We don't believe it is good for providers, the public, or the recipient.

Mr. PALLONE. OK. Thank you.

Dr. O'Shea, I believe that ensuring appropriate access to primary care is critical to improving our healthcare system, and one of the goals behind the ACA was moving our system to one of prevention so that we are not always treating sickness because of the cost, in part.

And, as you know, one of the provisions in the ACA was increasing payments for Medicaid primary care doctors to Medicare rates. Obviously, I think that is a good thing.

And I guess——let me just skip some of this and ask you the two questions because we are running out of time.

One, does the AOA support extending the primary care increase in Medicaid? And can you talk about what effect this bump has had across the country. And do you believe it is an effective way to address access?

Dr. O'SHEA. Can I say yes?

Mr. PALLONE. OK.

Dr. O'SHEA. No. Sir, the access to primary care is so necessary when you are actually talking about this mostly chronically ill. Why are——in California, we call it Medi-Cal.

Why a lot of times are they actually at this level? It is not just income. They have already had acute and then chronically ill patients that can't work, can't, you know, economically have their own ways to have higher care.

Yes. The bump has helped, especially in California, because there was a 10 percent cut not too many years ago where, you know, if you are not in a larger system, it is hard for smaller primary cares to actually accept those lower-paid patients. You know, they will pay us at something like 20 to 22 cents on the dollar for what other insurance will.

So, yes, you have the most needy population that then would cost the most for the hospital systems because that is where they are headed if they don't get the primary intervention earlier. That small boost has been made.

So primary care that has an efficient system can actually help those patients and it has been able to access more of those patients and provide care for them.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. GUTHRIE [presiding]. Thank you.

The ranking member Mr. Pallone from New Jersey's time has expired.

And I will recognize Mr. Long from Missouri.

Mr. LONG. Thank you, Mr. Chairman.

And thank you all for being here today.

Yesterday the subcommittee heard from policy experts with experience in building bipartisan consensus on Medicare reforms.

And when they were asked about whether further study of various options was needed, their view was that Congress has enough information already, we are kind of talking the thing to death, and

now is the time for Members to sit down and agree to a package of offsets to make SGR history.

So I want to start with Mr. Umbdenstock. Is that it?

Mr. UMBDENSTOCK. Yes, it is.

Mr. LONG. Something like that.

Mr. UMBDENSTOCK. Thank you.

Mr. LONG. I knew I would call you "Byalistock" or something.

But just a yes or no. I will start right there and go right down the line. Just a simple yes or no answer will suffice. And I want to hear briefly from each of you.

Do you believe now is the time for Members to sit down on a bipartisan basis and agree to bipartisan offsets on SGR reform? Yes or no.

Mr. UMBDENSTOCK. Yes, sir. And we have put some suggestions in our testimony. So we would be happy to talk to you about those.

Dr. O'SHEA. Emphatically yes, sir.

Dr. SPEIR. Yes. And, in part, your second question, if not now, when?

Mr. MILLER. Yes, sir.

Dr. MCANENY. Yes. We very much would appreciate you doing that. We have got such good policy that has come out of this committee. If we can push it over the line, we can get on with other changes we need to make. So, yes, please.

Mr. SCHNEIDEWIND. Yes, Congressman. We have a list of offsets that we have offered to help that process.

Mr. LONG. Unanimous. I like that.

Because like I——in Washington, sometimes we can get in the habit of talking things to death. And everyone wants to do something in a bipartisan fashion and the public wants to see that. Our constituents are always asking, "Why can't you do something in a bipartisan fashion?" And I think the time is now.

Mr. Umbdenstock, I realize that forging consensus within an industry trade association such as yours on changes to Medicare can be very challenging. However, the Hospital Association, as you know, has endorsed roughly $2 trillion in potential offsets for Congress to consider.

Given your success in getting your members around these offsets, do you have any insights you can offer in working to build cooperation and consensus with others in the provider community and the Members of Congress?

Mr. UMBDENSTOCK. Just a couple of quick comments, sir.

One would be that every thought we have about this has to be put up against the prospect of a 21 percent cut to physicians, with physicians probably backing——many of them backing out of the program and causing huge access problems for Medicare beneficiaries. Everything has to be seen in that light.

Number two, hospitals have already consumed——absorbed $121 billion in cuts, and we don't believe that we should be asked yet again to make sacrifice in that sense.

We need to see shared responsibility here. All of us need to contribute to the solution to this problem, and that is behind the paper that is appended to our testimony that went through about 500 different members in our group to put that together.

Mr. LONG. Do you think that we might suffer from a physician shortage if these cuts continue?

Mr. UMBDENSTOCK. Well, I think we already do. And we are supportive of lifting the caps on graduate medical education positions.

That is going to be a long-term solution. We need other solutions in the meantime. But certainly it is going to encourage some physicians to think second and third about continuing the program or even retiring.

Mr. LONG. That is exactly what I faced with my personal doctor. And a lot of people I know, doctors have retired. Most doctors I talked to are looking for a way out. And with my daughter just about to graduate medical school, I know that this doctor shortage is coming.

So, anyway, thank you all once again for your testimony.

With that, I yield back 60 seconds.

Mr. GUTHRIE. I appreciate the gentleman for yielding back.

The chair recognizes Mr. Bilirakis of Florida.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

First question is for Mr. Richard Umbdenstock. I hope I pronounced it all right.

Mr. UMBDENSTOCK. Yes, sir.

Mr. BILIRAKIS. In your testimony, you noted that traditional Medicare does not have an annual out-of-pocket maximum payment cap to protect seniors from financial hardship or bankruptcy in the event of a major illness.

Yesterday, as part of my questioning, Senator Lieberman talked about how important a maximum out-of-pocket protection——how important that is and how this is the reason most Americans buy health insurance. Makes sense. Unfortunately, traditional Medicare does not offer seniors this peace of mind.

Can you talk more about how this reform could lower Medicare spending and help seniors at the same time.

Mr. UMBDENSTOCK. Yes. Thank you very much.

One overall comment: I think we need to think about the fact that structural changes are one thing and where you set the dollar limits of responsibility are another thing.

If we just talk about dollar limits and impact without talking about structure and opportunities for change, I think we miss a lot of the important part of the conversation.

As you point out, we may focus heavily on premiums, but if we don't focus on total costs and total financial responsibility, we miss the bigger picture.

So, yes, we would be in favor, as we talk about the A and B construction or other structural changes, of seeing how we can maybe up the financial responsibility on some people——proper protections for those at low-income level, phase it in over time——do it right, but at the same time think about things that currently don't exist in the program, such as a cap. And that would be——in a catastrophic sense, that would be really important to do.

Mr. BILIRAKIS. Thank you so much.

Again, for you, sir, according to the CBO, Medicare spending will continue to climb over the coming decade, totaling more than $1 trillion in 2024.

One of my worries is that, as Medicare costs grow and consume more general revenue dollars, it will crowd out other domestic discretionary priorities, such as NIH research and, of course, the VA health care, which I care about deeply.

What Medicare reforms do you think could be adopted with the SGR that would help curb Medicare spending the most?

Mr. UMBDENSTOCK. Well, as was pointed out by the gentleman just a minute ago, we have put forth several suggestions in our testimony.

We have also looked across all of the items that have been scored by CBO in the healthcare space and have offered that up on our Web site as a longer list of possibilities.

I think we would have to talk about what changes and in combination with what other changes rather than any one major bullet, so to speak. May be a bad choice of term. Pardon me. But the ones that we put forth in our testimony are ones that we think hold great promise and should be examined.

Mr. BILIRAKIS. OK. I would like to maybe mention one again for you, Mr. Umbdenstock.

According to the Social Security Administration data, there are thousands of seniors with annual incomes of more than a million dollars.

In your testimony, you address the issue of premiums and mention the Government subsidizes the premiums for everyone, including millionaires. You also mention that the American Hospital Association supports increasing income-related premiums.

Can you talk about why you think it is reasonable to charge them more.

Mr. UMBDENSTOCK. Well, I think each of us has to share in this responsibility individually as well as organizationally. So that is the first principle.

Secondly, we do want to see protections continue for those of low income and low means for sure. It doesn't help us at all to charge something to somebody that they can't afford.

That just increases administrat——it certainly increases the negative experience for the patient. It increases our administrative costs. It increases our bad debt.

We have had debates with Congress over the level of our bad debt reimbursement. So it doesn't solve any problem for us.

But where somebody can afford it and where we can do it more efficiently with the right protections for those who can't, I think we should.

Mr. BILIRAKIS. Very good.

Thank you, Mr. Chairman. I will yield back my 29 seconds. Thank you.

Mr. GUTHRIE. Thank you.

The gentleman yields back his time.

Mr. Bucshon of Indiana is recognized for 5 minutes.

Mr. BUCSHON. Thank you, Mr. Chairman.

And many of you know I was a practicing cardiovascular and thoracic surgeon for 15 years prior to coming here. And this is one of the issues that got me to come here because I have a big concern, as we all do, basically, at the end of day, about our patient.

And that is what this is all about. Everything we discuss today needs to be framed in the context of how we can better take care of patients, and I think that is what I try to do.

I have supported outside pay-fors——pay-fors outside of the healthcare sector to try to address the SGR historically. And, by the way, I did submit all of my cases to the STS database.

And I think the STS database is really on the forefront of quality analysis and it does definitely, I can tell you from personal experience, direct where you practice your——how you practice your medicine.

I always compared myself to my peers and saw how things were going and tried to do everything I could to improve the quality of the care that I offered.

The other thing is, briefly, when you also——in addition to the SGR, we clearly need to address overall healthcare costs. One of the ways to help Medicare, of course, is to have the cost of healthcare come down.

And we need more, I think, as the STS database attests, quality information as well as price transparency for the consumer, which is a huge problem, in my estimation, as well as tort reform, which has been discussed. And there is a laundry list of other things that can help us get the overall cost of healthcare down.

Dr. McAneny, I am going to ask you about——the AARP, as well as the AHA, have submitted ideas on the pay-fors for SGR. And, historically, the AMA has supported repealing the SGR without pay-fors. We could use your——we can really use your help——your organization's help in offering pay-fors.

Can the AMA offer some substantial possible pay-fors for us to look at to help us repeal the SGR?

Dr. MCANENY. Thank you very much for that question.

It is a very difficult one because, within the healthcare sector, so many people are struggling now just to keep their doors open to their patients that for us from within the healthcare sector to really come up with a specific pay-for may not be as useful until there are some guidelines set up by Congress on what are the rules of this particular budgetary process, how do we fit those things within that.

I think the AMA stands ready to assist and help by weighing in on any given suggestions, but I think we are very uneasy and feel that we don't really have the ability to give you specific pay-fors. The devil in this is all very much in the details. So——

Mr. BUCSHON. The reason I say that is because——I think it is important that you really seriously consider offering some options.

And the reason I say that is because, in the public's mind——okay?——the support of the AMA on an issue, for better or for worse, is often used as an up-or-down on something related to healthcare. And you know this as well as I do.

Dr. MCANENY. Right.

Mr. BUCSHON. Because, if the AMA, for example, offered pay-fors, you know, around the country when this discussion comes up, it will list in there, "And the AMA supported this."

If the AMA is not there and the AMA doesn't comment, then it is going to say, "Well, we asked the AMA and they didn't respond

to our request" and so it appears that the AMA may not be supporting.

You understand what I am saying?

Dr. MCANENY. [Nonverbal response.]

Mr. BUCSHON. And what it is used for is it is used politically. It is political. It is a political way to——if something is not tenable to certain groups, to use the AMA's up-or-down support on an issue as the reason for why it is not happening.

And so I would just implore you to really reconsider that——you know, the AMA reconsider and maybe help us rather than waiting, you know, for other options and then coming out and saying, "Well, up or down, we disagree" or "we agree."

I mean, I think, in all of our lives——right?——if you are going to offer an opinion at the end, then you should be part of the——offering solutions on the front side.

Because, in fairness, I think, you know, whether it is within your own family or whether it is to solve this problem, if you are just going to wait and be a critic and not offer solutions yourself, to me, that is not very helpful.

So with the remaining 18 seconds, just please reconsider and try to really help us. You can help us with this problem with offering solutions.

Mr. Chairman, I yield back.

Mr. GUTHRIE. Thank you.

The gentleman yields back.

Mr. Griffith of Virginia is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate it.

Let me touch on tort reform, medical malpractice, just briefly.

I heard the testimony about California's plan. Works great for California. But we have had some bills in the past that wanted to take the California model and apply it nationally.

One of the problems I have with that, coming from Virginia, is that California has a comparative negligence model in their entire——all of their torts, not just medical malpractice.

Virginia is not a comparative negligence state. It is a contributory negligence state. So if you adopt the California model——it is one of the things we have to be careful for in Congress. If we adopt the California model and apply it statewide, we completely reverse 400 years of Virginia law.

There are ways to have tort reform without making it one-size-fits-all from Washington, and I think that is probably what most people would want us to do. So we just have to be careful.

So if occasionally you see people talking about tort reform and then something happens on the way from here to the floor, you understand why that might occur.

But you would agree that tort reform——and I will ask the gentlelady the question from California.

You would agree that tort reform is something that would be helpful in this process as long as we make sure we are not trampling over the general laws of the State?

Dr. O'SHEA. I totally agree. And I can say, being a practicing physician in California, our Practice Act had been opened. And so it might be analogous to that, that you always have to——that the

Pandora can jump in and many Pandoras jump back in again, out and in.

But if it is an access to patient care, if it is not abling especially specialists or even primary care——if they want to treat indigents, if they want to treat others, you are lowering their ability to have their own funds that they need, that they have to generate some way. So there is another way. Is it coming from or is it going out of?

So I would totally agree that we have to be sensitive to each State, but limiting malpractice is something that needs to be done.

Mr. GRIFFITH. And I would hope that the other respective States would do what California has done, what Virginia has done, what Texas has done now. And each State has their own model.

In Virginia, they have done a great job. And I can't take any credit for it, although I served there. But the doctors and the trial lawyers got together and came up with caps.

And sometimes they argue about it, but they come to the legislature generally with a plan of what we want to do, does the cap need to be raised, does this need to be changed, et cetera.

And they have worked together as opposed to getting into pitched wars, which makes it a lot easier on legislators to figure out, "OK. If they are in agreement and they can both live with it, then it is probably makes pretty good sense." And I would encourage the other States to do that as well.

Let me ask Mr. Schneidewind this. Last May the Office of the Actuary at CMS said that Medicare's hospital insurance trust fund could be insolvent as soon as 2021 or as late as 2030. Under current law, there is no ability for the program then to pay claims on behalf of seniors.

Given these empirical facts, do you acknowledge that, if left unaddressed, Medicare's coming insolvency could present an access problem for seniors on Medicare? It is an easy answer.

Mr. SCHNEIDEWIND. Well, if it doesn't have the funds to pay claims, it would certainly have an impact on seniors.

Mr. GRIFFITH. Absolutely.

On another policy issue both for you and the AMA, the President's 2015 budget to Congress includes a proposal that would apply——or included a proposal that would apply a $25 increase to the Part B deductible in 2018, 2020 and 2022, respectively for new beneficiaries. Beginning in 2018, current beneficiaries or near-retirees would not be subject to the revised deductible.

Has your organization taken a position on this policy? And, if so, what is it?

Mr. SCHNEIDEWIND. Yes. We have taken a position in opposition to that proposal.

And we have said before the burden of medical costs on our members is significant. Half of them have an income of less than $23,500 a year and they pay——on average, that group pays $4,000 for medical costs. Also, as Medicare premiums, Part B, are raised, they pay those increases.

So imposing yet another deductible increase or expense on this group is really, we think, unaffordable, and we think there are far better ways to restrain costs in healthcare, in general, and in the

Medicare program, in particular, than raising premiums or deductibles.

Mr. GRIFFITH. And Dr. McAneny.

Dr. MCANENY. Thank you for the question.

We don't have any immediate policy on the President's budget proposal that we just heard on the State of the Union very, very recently, but we do have policy that we want to help consumers pay our patients to spend wisely and make wise choices.

Many of our specialty societies have adopted programs that we work with on choosing wisely to use those procedures that are helpful and not use the ones that are not needed or could be avoided.

There is literature that deductibles and co-pays can both decrease access to useful care as well as unuseful care. So we think that this is going to be a more complicated issue. We will be happy to get back to you on that and work our way through that.

Mr. GRIFFITH. I appreciate that very much. Appreciate your testimony.

And I yield back.

Mr. GUTHRIE. Thank you. The gentleman's time has expired.

All Members seeking recognition have been recognized. And I want to remind Members that they have 10 business days to submit questions for the record.

And I ask the witnesses to respond to the questions promptly.

Members should submit their questions by the close of business on Thursday, February the 5th.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:34 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

House Energy and Commerce Committee's Subcommittee on Health Hearing on,

"A Permanent Solution to the SGR: The Time Is Now"

January 21, 2015

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Introduction

This statement is submitted to the House Energy and Commerce's Subcommittee on Health on behalf of the 115,900 members of the American Academy of Family Physicians (AAFP) for the January 21 hearing titled, *A Permanent Solution to the SGR: The Time is Now.*

Since 2003, Congress has enacted 17 short-term fixes to address the flawed Medicare Sustainable Growth Rate (SGR) formula. The temporary patches, or "doc fixes," have cost more than $160 billion during that time. While the AAFP is pleased Congress approved these short-term patches, it is unfortunate that the 113th and previous Congresses failed to enact a long-term SGR repeal-and-replace bill.

The AAFP appreciates the Subcommittee's robust health care agenda and current efforts to address SGR reform. We view this goal as a top legislative priority and stand prepared to work with Members of the Subcommittee to enact legislation this session that builds on the bipartisan, bicameral agreement. As the Subcommittee moves forward, the AAFP offers you our key health care principles and legislative priorities within the context of Medicare payment reform.

Health Care Principles

A Strong Primary-Care System

Primary care is the foundation of an efficient health care system. Efforts to enact federal health program reforms should increase access to primary care and ensure that the nation's system for providing these services is strong. Primary care is comprehensive, first contact, whole person, continuing care. It is not limited to a single disease or condition, and can be accessed in a variety of settings.[1] Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists.[2]

Research shows that preventive care, care coordination for the chronically ill, and continuity of care – all hallmarks of primary care medicine – can achieve better health outcomes and cost savings.[3] The benefits also translate into healthier communities.[4] Published studies have demonstrated the positive impact of primary care on a variety of health outcomes, including decreased mortality from cancer, heart disease, stroke, and all causes combined.[5] Primary care clinician capacity is also associated with fewer low birth weight infants, increased life expectancy, and improved self-rated health. An increase of one primary care physician per 10,000 people was associated with an average mortality reduction of 5.3 percent, or 49 per 100,000 per year.[6] In addition, high quality care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering costs.[7]

Therefore, it is in the national interest to support a strong and efficient primary care system. This is especially true for the treatment of America's aging population, which represent a large majority of the Medicare population. According to a recent Kaiser Family Foundation report, by the year 2050, the number of people 65 years of age and older will nearly double.[8] This population trend is associated with higher forecasted per capita spending for beneficiaries between 65 and 85 years of age.[9] In 2020, Medicare costs are projected to consume 17 percent of the federal budget, a significant level, but, to date, increased spending has not produced a proportionate improvement in the nation's health.[10] In fact, America ranks 37th in health status compared to other nations.[11]

The factors driving Medicare costs are chronic care management and costly fee-for-service care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one.[12] The high utilization of specialty care combined with its reliance on expensive technology results in higher priced medicine – even when treating the exact same conditions.[13] Successful management of these conditions within primary care means patients are healthier; make fewer trips to the hospital and doctors' offices *and* utilize less expensive medical care. According to a 2004 study commissioned by the Medicare Quality Improvement Organization, states with more primary care supply have lower cost per Medicare beneficiary. Essentially, primary care access contributes to a stronger and more fiscally sound Medicare program.

Appropriate Physician Payments for Quality and Complex Care Delivery

The nation's primary care physicians are committed to the health and well-being of their patients, but increasingly they practice medicine under challenging conditions.[14] For example, the current payment system is unpredictable and does not reflect the value primary care provides to the health of Medicare beneficiaries. Instead, it rewards procedures, tests, technology and acute care rather than preventive health care, the coordination of care and chronic disease management. Payment methodologies need to be re-balanced to establish a predictable and equitable payment formula that appropriately compensates physicians for care provided. A new payment formula should invest more in primary care as a percent of overall total cost of care and is essential to improving the health and health care of Medicare beneficiaries and controlling costs. Such an increased investment in primary care payment would be significant to reduce the current disparity in payments compared to subspecialty care, which contributes to the growing primary physician workforce shortage and the escalation of health care costs.[15]

Family physicians, in comparison to other medical specialties, offer a broader range of care, inclusive of the care of patients with complex conditions. Primary care physicians provide care for a larger number of diagnoses than non-primary care specialists and correspondingly provide three times as many distinct physician services. A 2014 report by the Robert Graham Center found that on average, primary care physicians report 23 diagnosis codes, while cardiologists, for example, report six.[16] Payers and policy makers should recognize this complexity of care.

AAFP Legislative Priorities

Based on the important framework of the bipartisan, bicameral legislation, which proposed strengthening primary and more appropriately paying for physicians' services, the following represents the AAFP's policy priorities.

Repeal of the Medicare Sustainable Growth Rate (SGR)

The AAFP strongly supports the immediate repeal of the Medicare sustainable growth rate (SGR) formula. Under the SGR, physicians face unpredictable payments into the foreseeable future even while their practice costs continue to increase. According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business that delivers medical care. This system of non-aligned incentives, especially fee-for-service alone, rewards individual physicians for ordering more tests and performing more procedures – for volume over value. The system lacks incentives for physicians to coordinate those tests and procedures, or patient health care generally, or to offer preventive and health-maintenance services. This payment method has produced expensive, fragmented health care delivery.

Congress is well aware of the troublesome history of this payment formula, since policy makers have had to override the reductions in the physician payment rate mandated by the SGR. These perennial reductions threaten the stability of the Medicare program and the access of seniors to Medicare benefits. The looming threat of frequent reductions also stifles innovation in care delivery and hinders the transformation of primary care practices. Investments in process and quality improvement have proven difficult for most physicians under the current unpredictable payment structure. The AAFP has long advocated for repeal of the SGR – so the primary care delivery system can flourish through innovation unencumbered by a flawed payment structure and can provide quality care to patients.

Stable Payments and Performance Measures

Stable payment rates and performance measures are important and welcome reforms. The changes in the previous legislation would provide physicians with much-needed efficiency and predictability. The 2014 legislation would stabilize payment rates permanently by specifying an annual update increase of 0.5 percent through 2018 and then freeze the rate until 2023 followed by further positive updates in 2024 and thereafter. Under the bipartisan agreement, physicians would receive additional payment adjustments in the 2018-2023 period through the Merit-based Incentive Payment System (MIPS), a reform of the current fee-for-service system. MIPS is based on consolidation of three current performance-based programs: (1) The Physician Quality Reporting System (PQRS) that incentivizes physicians to report on quality of care measures; (2) The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use; and (3) Meaningful Use of Electronic Health Records (EHR MU) that calls for meeting certain requirements in the use of certified EHR systems. In short, the real value of the SGR repeal legislation from the 113th Congress is that it not only eliminates the current SGR formula but

most importantly it creates the pathway for moving away from a total reliance on fee-for-service payment to alternative payment models which can be supportive of primary care and the achievement of the Triple Aim of better care, better health, and lower cost.

In addition, the AAFP supports the elimination of penalties associated with the PQRS, VBM and EHR MU programs after 2017. Instead, MIPS would assess the performance of those physicians billing Medicare who are not in Alternative Payment Models (APM). The assessment would be made in four categories: quality; resource use; EHR meaningful use; and clinical practice improvement activities. A composite performance score is created from these assessments and payments would be adjusted in the subsequent year based on the composite score. If approved, reducing the administrative duplications and paperwork burdens within these three programs will be an improvement in the health care delivery system.

Quality-Based Health Care Delivery Reforms

Care coordination is a key element of primary care. Within the framework plan, physicians who have a significant share of their Medicare revenues in an Alternative Payment Model (APM) that involves two-sided financial risk and a quality measurement component would receive a 5 percent bonus each year from 2018 and thereafter. Physicians participating in a qualifying APM would be exempt from the reporting and performance thresholds established by the Merit-based Incentive Payment System (MIPS). Physicians, who have a significant share of their Medicare revenue in a patient-centered medical home model that has been certified as maintaining or improving quality, and without increasing costs, are also eligible for the 5 percent bonus in 2018 and in subsequent years. Most often, these will be family physicians.

The AAFP strongly recommends that Medicare incorporate the patient-centered medical home (PCMH) concept into the program because it has shown to improve not only the quality but also the delivery of health care. Currently, 26 percent of AAFP members operate as part of a federally-recognized PCMH. An efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more effective use of resources and that result in better health outcomes.

Patients, particularly the elderly, who have a usual source of care, like a medical home, are healthier and the cost of their care is lower because they use fewer medical resources than those who do not. An abundance of evidence shows that even the uninsured benefit from having a usual source of care.[17] Individuals with a usual source of care receive more appropriate preventive services and more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when it is necessary.[18] A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is prevented.

Care Coordination Payments

The AAFP supports provisions within the bipartisan, bicameral agreement that would create a Medicare payment within the fee-for-service system complex chronic care services. The AAFP has long urged CMS to pay for care coordination and other cognitive services that play a pivotal role in enhancing health care access, improving quality and controlling costs. A care coordination payment would compensate eligible physicians for those services generally provided outside a traditional face-to-face encounter. The AAFP would support efforts to permanently codify the care coordination payment into law with a provision that these services not be subject to co-payments or deductibles when they are provided by primary care physicians.

Accurate Valuation of Services

The AAFP supports redistribution of relative value units (RVU) within the fee schedule to achieve accuracy. Under current law, CMS has the authority to adjust the fee schedule. Congress has added new authority to adjust misvalued codes, in order to reduce overvalued services and increase undervalued services. Congress has since accelerated that process. The AAFP supports this process, but only if the savings are retained within the fee schedule.

Primary Care Incentive Payment

Currently, the Centers for Medicare and Medicaid Services (CMS) pays primary care physicians (defined as those with a specialty designation of family medicine, internal medicine, geriatric medicine or pediatric medicine) an additional 10 percent for primary care services, defined essentially as evaluation and management services. This incentive payment program expires on December 31, 2015. The goal is to recognize, to some degree, the value of primary care and to improve compensation for these services. Family Medicine appreciates the underlying message of the provision, but is asking Congress to increase the payment and make it permanent for all federal health care payment programs, including Medicaid. Otherwise, the incentive is too limited to achieve its important goals.

Conclusion

As Congress moves forward to repeal the SGR and reform Medicare payments, the AAFP urges policy makers to do so in a way that supports primary care and appropriately pays physicians for the care that they provide. A strong primary system benefits the Medicare program and is fiscally sound policy. Again, the AAFP is pleased to work with the Subcommittee to advance SGR repeal-and-replace legislation based on the bipartisan, bicameral framework approved in 2014, and looks forward to working with you to enact this important policy into law.

For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org

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Testimony on behalf of the American Ambulance Association (AAA)
House Committee on Energy and Commerce - Subcommittee on Health
Hearing on "A Permanent Solution to the SGR: The Time Is Now"
January 21-22, 2014

The American Ambulance Association (AAA) thanks the Chairman, Ranking Member and Members of the Subcommittee on Health for holding a two-day hearing to examine a permanent solution to the Sustainable Growth Rate (SGR). We urge Congress to develop a long-term remedy for Medicare physician payments that will correct a decade-long problem that has created uncertainty for millions of Medicare physicians and beneficiaries. Other Medicare providers also face uncertainty regarding reimbursement year after year. As you are likely aware, ambulance service providers currently receive temporary two percent urban three percent rural and "super rural" increases in Medicare payments. This vital relief is extended each year as one of the Medicare extenders included in the physician fee fix extension package. Medicare reimbursement represents a substantial portion of total payments for ambulance service providers with Medicare patients accounting for on average 50 percent of ambulance transports. AAA implores Congress to move away from the uncertainty of temporary relief and toward the predictability, certainty and stability associated with permanent payment policies for ambulance service providers as part of our nation's health care safety net.

Ambulance service providers are a critical piece of our local and national health care and emergency response systems. They are also overwhelmingly small businesses, which provide jobs and investments in local communities. Unfortunately, due to chronic below-cost Medicare reimbursement, ambulance service providers are financially challenged. In 2002, the Centers for Medicare and Medicaid Services (CMS) established a Medicare ambulance fee schedule, but the rates developed were significantly below the cost of delivering services as the Government Accountability Office (GAO) confirmed. GAO's two reports (published in 2007 and 2012) underscored that reimbursement for treating and transporting Medicare beneficiaries is unstable and often lower than the cost of providing the services, endangering the availability of emergency medical services for our nation's seniors and everyone else. Both GAO reports concluded that but for the temporary add-on payments, most service providers would be reimbursed below cost. To ensure the continuity of emergency medical care and financial viability of these small businesses, Congress needs to make the temporary Medicare ambulance relief permanent. This will allow us to budget over the long-term for staffing, replacing equipment and ensure that we can continue to efficiently serve the communities that rely on us for medical care. As Congress considers permanent repeal of the SGR, it is imperative that Congress concurrently address other "Medicare extenders" in order to break the cycle of short-term patch approach to Medicare legislation.

AAA thanks Congress for recognizing the significant underfunding that ambulance service providers have faced and we sincerely appreciate the continued payment adjustments for urban transports, rural transports and transports in "super rural" or extremely remote areas.

However, the most recent extension included in the Protecting Access to Medicare Act (PAMA) is set to expire on March 31, 2015, and our ambulance services providers face uncertainty yet again. Congress must ensure that the dedicated men and women who provide critical emergency medical services have the tools and resources they need to provide the high-quality services that is demanded of them. Legislation is expected to be re-introduced in the 114th Congress by Representatives Walden, Neal, Nunes and Welch that institutes meaningful ambulance policy reforms and makes the current relief permanent. The *Medicare Ambulance Access, Fraud Prevention, and Reform Act* would allow ambulance services providers to better plan for staffing and equipment replacement and/or upgrades. Further, the legislation would implement a nationwide prior authorization program to address fraud, abuse and waste in the transport of dialysis patients. The legislation would also categorize us more properly as ambulance service *providers* instead of *suppliers*. Lastly, the bill would direct CMS to use a survey approach to collect cost data from a statistically significant number of different types of ambulance service providers. AAA believes it is critical that Congress have cost data from all the different types of providers if policymakers seek to make any changes to the ambulance fee schedule in the future, and this approach would achieve the same critical information without the excessive regulatory burden of mandatory cost reporting.

Ambulance services not only create good jobs and investment, but they provide critical, life-saving medical care, regardless of one's ability to pay. While they are the first in line in the continuum of health care, they are often the sole provider of emergency and non-emergency ambulance services in their communities. They respond when called – no questions asked. Ambulance service providers are lifelines of care for a wide range of individuals, including seniors who rely on Medicare. As the Subcommittee's title claims, the time *is now* to pass permanent SGR reform, and with that we urge Congress to also permanently address ambulance service provider payments.

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

"A Permanent Solution to the SGR: The Time Is Now"

January 21 & 22, 2015

Submitted Testimony
regarding
Standards of Care and Federal Healthcare Guidelines

The Cooperative of American Physicians, NORCAL Mutual Insurance Company, PIAA, Texas Medical Liability Trust and The Doctors Company would like to thank Chairman Pitts, Ranking Member Green, and the distinguished members of the Subcommittee on Health for providing us this opportunity to submit testimony on the important issue of standards of care as they relate to reform of the Sustainable Growth Rate formula. As leaders within the medical professional liability (MPL) community, we have a great interest in ensuring that all aspects of our health system work for the benefit of both patients and healthcare providers.

Background

MPL (sometimes referred to as medical malpractice or medical negligence) standards of care have traditionally been addressed at the state or local level. Generally speaking, any MPL claim requires a determination of the applicable standard (or duty) of care in the community and whether the medical provider adhered to that standard of care. The standard of care is ordinarily established by an expert witness who relies on a variety of evidence sources such as their own experience, peer-reviewed medical literature, medical specialty society guidelines and practice standards in the state or locality.

Federal Health Care Payment Incentives

During the past decade, the federal government has moved to tie federal payments to healthcare providers to their compliance with requirements intended to improve the cost efficiency or quality of healthcare services. These requirements include the following:

- Tying a portion of Medicare payments to a requirement that physicians electronically prescribe drugs.
- Conditioning Medicare payments to physicians on their compliance with reporting requirements on certain quality measures.
- Denying additional Medicare payments for costs attributable to certain "healthcare acquired conditions" (HACs) that are deemed to have been reasonably preventable.
- Providing incentives to encourage healthcare providers to use certified electronic health records systems (and subsequent penalties for failure to adopt such systems).

These initial efforts to condition federal healthcare payments on the accomplishment of certain objectives were dramatically expanded as part of the Patient Protection and Affordable Care Act (ACA). Under the ACA literally dozens of new payment rules and programs were implemented, including:

- Imposition of a value-based payment modifier for physician services.

- Expansion of the Physician Quality Reporting System that partially conditions payment on quality metrics.
- Creation of Accountable Care Organizations that tie a global payment to cost savings and quality metrics.
- A "bundling" demonstration project that provides a global payment for an episode of care and measures adherence of that care to a variety of measures.
- Expansion of the HAC program to Medicaid and to require payment sanctions under Medicare for hospitals falling into the lowest quartile in terms of the number of HACs.
- Creation of a new Value Based Purchasing modifier for hospital payments.
- Creation of new measures of "avoidable" hospital readmissions and associated payment sanctions for hospitals with excess levels of readmissions.
- A new "quality star" bonus system for Medicare Advantage plans.

Most recently, the *SGR Repeal and Medicare Provider Payment Modernization Act* passed by the House of Representatives last year created additional value-based requirements, including:

- Consolidating the three existing quality programs into a streamlined and improved program that rewards providers who meet performance thresholds, improve care for seniors, and provide certainty for providers.
- Incentivizing care coordination efforts for patients with chronic care needs.
- Introducing physician-developed clinical care guidelines to reduce inappropriate care that can harm patients and results in wasteful spending.
- Requiring the development of additional quality and performance measures.

Please understand that we are extremely supportive of efforts to improve the quality and efficacy of healthcare in the United States. Indeed, MPL insurers are leaders in the effort to improve patient safety and ensure better health outcomes. Our concern, however, is the potential for misuse of regulations and guidelines that are intended to provide better patient care.

The Risk

The drive to tie Medicare and Medicaid payment rules to various incentives intended to promote improvements in cost efficiency and the quality of care has generally been supported on a bipartisan basis, and rightfully so. It must be noted, however, that the rules that have been implemented and will be implemented in the future have not been developed with the intent that they should be applied in medical professional liability cases to determine the applicable standard of care. Indeed, many of the new rules are the subject of sharp disagreement. For example, both the American Hospital Association and the American Medical Association believe that CMS' list of reasonably

avoidable healthcare acquired conditions is neither accurate nor necessarily demonstrative of the quality of care.

There is a danger in conflating these government payment rules with liability standards and compliance with or deviation from these rules was never intended to serve as the basis for protection from or exposure to litigation. Unfortunately, the beginnings of this trend are starting to appear. A quick search of the internet, for example, reveals dozens of legal websites discussing how the CMS designation of an HAC can ease the burden of demonstrating provider negligence. As insurers, we are also aware of a growing trend at the trial court level to experiment with various theories of liability tied to government payment rules. Consider some of the following potential uses:

- Theories of strict liability or enterprise liability could be applied to hospitals with higher than average HACs or readmissions. Under such theories, actual negligence (deviation from the standard of care) need not be demonstrated.
- Physicians who are in compliance with PQRS reporting requirements with respect to a certain condition, or who receive enhanced payments under the value-based modifier, could argue for plaintiff's to meet a higher standard of proof with respect to proving negligence.
- Plaintiffs could argue that a provider's failure to meet a particular quality metric for their overall population should be evidence of negligence with respect to a particular case where that metric is implicated.
- A Medicare Advantage plan could use its ascertainment of a five star quality rating as a defense to a liability action.

As these examples suggest, the confusion of payment rules with liability rules would be harmful to both the legal process for resolving negligence actions and the government's efforts to promote value based purchasing. Among other outcomes, the development of these payment rules will become embroiled in extensive contention if they are to be allowed to be used as legal evidence.

The Solution

Congress can and should act now to clarify the demarcation of new incentive-oriented payment rules and liability rules. Simple legislative language that articulates that these payment rules should not be construed as liability rules is all that is needed (see attached). Indeed, such language was already included in the SGR repeal legislation which passed the House last year and in the SGR repeal bills put forth by both Republican and Democratic leaders of the Senate Finance Committee.

The scope of this legislation is quite modest. It would simply preserve the status quo with respect to the medical professional liability adjudication process. It would not

change current law, or alter the way courts seek to determine if an act of medical negligence occurred. It would not provide new protections from medical liability lawsuits. It would not, in any way, affect the ability of an expert witness to discuss the applicable standard of care. Instead, it would simply ensure that federal rules and guidelines were not used for legal purposes for which they were never intended, and in the process guarantee the judicial playing field was not inadvertently tipped to favor either defendants or plaintiffs.

The federal government is today at the beginning of a long journey toward greater adoption of payment incentives and systems to promote value in the purchase of healthcare goods and services. Simple and straight forward legislation to clarify at the outset the respective roles of payment rules and liability rules should be adopted to the benefit of all interested parties.

Recommend Standard of Care Language

SECTION 1. SHORT TITLE.

This Act may be cited as the `Standard of Care Protection Act of 2015'.

SEC. 2. RULE OF CONSTRUCTION REGARDING HEALTH CARE PROVIDER STANDARDS OF CARE.

(a) Maintenance of State Standards- The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed--

(1) to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim; or

(2) to preempt any standard of care or duty of care, owed by a health care provider to a patient, duly established under State or common law.

(b) Definitions- For purposes of this Act:

(1) FEDERAL HEALTH CARE PROVISION- The term `Federal health care provision' means any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or title XVIII or XIX of the Social Security Act.

(2) HEALTH CARE PROVIDER- The term `health care provider' means any individual or entity--

(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(3) MEDICAL MALPRACTICE OR MEDICAL PRODUCT LIABILITY ACTION OR CLAIM- The term `medical malpractice or medical product liability action or claim' means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(4) STATE- The term `State' includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

SEC. 3. PRESERVATION OF STATE LAW.

No provision of the Patient Protection and Affordable Care Act (Public Law 111-148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

Testimony for the Record
Submitted to
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing on "A Permanent Solution to the SGR: The Time Is Now"
Wednesday, January 21, 2015, and Thursday, January 22, 2015
By
Bruce Siegel, MD, MPH, President and CEO
America's Essential Hospitals

America's Essential Hospitals appreciates the opportunity to submit testimony on reforming the sustainable growth rate (SGR) to the Subcommittee on Health of the U.S. House of Representatives Committee on Energy and Commerce.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care—not only for those in need, but for entire communities. Our more than 250 essential hospital members are vital to their communities, providing primary care through trauma care, health professionals training, research, public health programs, and other services.

Our members also employ many physicians in hospital and outpatient clinic settings. As such, any action to fix the broken SGR formula would affect these hospitals. We believe that ongoing, bipartisan work in Congress to repeal and replace the SGR represents the best opportunity to solve a problem that has plagued the health care industry for more than a decade. If Congress fails to act, the broken system will persist and further damage access to health care for our nation's most vulnerable people.

If Congress determines that the cost to repeal the SGR should be offset, America's Essential Hospitals would stridently oppose any offset that comes at the expense of hospitals or that damages access to and the quality of care for low-income patients. Since 2010, federal spending in the hospital industry has declined by more than $115 billion. In 2012, our member hospitals

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reported an average operating margin of *negative 0.4 percent,* and about 45 percent reported losing money. They simply cannot absorb additional cuts to hospital reimbursement. Further reductions would profoundly compromise these hospitals' ability to provide high-quality health care services to all patients and communities.

With this in mind, we welcome the opportunity to engage in the important process of developing a lasting solution for Medicare physician payments that will end the cycle of annual SGR patches and create meaningful incentives for improving the nation's health care system.

Bringing stability and sustainability to Medicare physician payments is vitally important now, as hospitals and other providers—and their patients—face growing uncertainty in health care delivery and financing. Broadly available health care coverage under the Affordable Care Act (ACA) remains out of reach for many. About half the states have rejected Medicaid expansion and the outlook for reversing those decisions is unclear. A looming Supreme Court decision makes the future of health insurance marketplace subsidies tenuous. And with or without subsidies, many people still cannot afford the cost of marketplace plan premiums and cost-sharing.

Hospitals—especially essential hospitals—face a similarly unsettled future. While Congress has wisely chosen to delay the ACA's damaging reductions in Medicaid disproportionate share hospital (DSH) payments, years of significant DSH cuts remain on the horizon without further congressional action. Even without Medicaid DSH cuts, our hospitals face more than $1 billion in federal funding reductions in fiscal years 2014 to 2016 alone, and additional deep cuts over the next decade—including more than $50 billion in DSH funding. Lessening this uncertainty with a long-term solution for Medicare physician payments would help ease concerns about care access and quality for the nation's underserved.

As Congress considers proposals to reform the physician payment system, we urge lawmakers to give stability and sustainability high priority. Congress also should ensure payment systems support providers' ongoing operational needs and health care access across the entire community. Payment systems should be designed to generate beneficial changes in the marketplace, including promoting quality and cost-containment, eliminating care disparities, and giving providers the data and other tools they need to achieve quality and cost goals.

New payment methodologies should reflect the input of all key stakeholders and should be tested thoroughly before widespread use. And policymakers should remain mindful that one size does not fit all—additional resources and adjustments might be required to account for patients with complex needs and sociodemographic challenges.

Hospitals have endured a decade of short-term SGR patches financed through reductions in hospital payment rates. Solving one side of the provider equation must not come at the expense of the other—particularly the hospitals and health systems that care for a disproportionate share of Medicaid, uninsured, and other low-income patients.

We are committed to working with Congress to find a permanent solution to the Medicare physician payment problem, and ask that lawmakers stay mindful that additional cuts would harm the ability of hospitals to meet their commitment to underserved populations. Hospitals and health systems are already facing deep Medicare and Medicaid payment cuts under the ACA and sequestration. Stable and adequate Medicare payment for both physicians and hospitals is essential to the shared goal of increasing access to high-quality, innovative care, and is key to aligning incentives that promote care coordination and integration. As we consider ways to improve physician payments, we also must shore up support for hospitals, including further delaying DSH cuts and considering whether we can still justify these cuts in light of shortfalls in Medicaid expansion and other coverage. In the end, reforming Medicare physician payments must strengthen the *entire* health care system.

We appreciate the opportunity the Subcommittee on Health has given us to share our thoughts on reforming the SGR. If committee members or other interested parties wish to learn more about essential hospitals in the context of this or other issues, contact Shawn Gremminger, director of legislative affairs, at 202-585-0112 or sgremminger@essentialhospitals.org.

- Another 42 percent would be expected to receive coverage from an employer, either as active workers or retirees, rather than Medicare:
  - 22 percent (1.1 million) of this group would be covered by an employer-sponsored retiree health plan; for these individuals, the employer plan would become their primary source of health insurance coverage rather than being a supplement to Medicare.
  - 20 percent (1.0 million) would be covered as an active worker by an employer plan because they or their spouse are working beyond age 65; these adults would retain their primary employer-sponsored coverage but would not have secondary coverage provided by Medicare.
- The remaining 20 percent (1.0 million) of 65- and 66-year-olds would be covered by Medicaid, including 130,000 individuals who would have been covered by both Medicare and Medicaid (full dual eligibility) if the eligibility age was 65, and 860,000 people who would qualify for Medicaid under the ACA because they have incomes up to 133 percent of the FPL.

Medicare would continue to cover some 770,000 high-cost 65- and 66-year-olds who qualified for the program prior to reaching age 65 because of disability.[19] Their eligibility would not be changed as it would be for other individuals ages 65 and 66.

OUT-OF-POCKET SPENDING

Raising the age of eligibility for Medicare is expected to affect beneficiaries' out-of-pocket spending, but the direction and magnitude of the change depends on a number of factors, most importantly whether beneficiaries would be covered by Medicaid or would receive subsidies for Exchange coverage. In the aggregate, raising the age of eligibility to 67 in 2014 is projected to result in an estimated net increase of $3.7 billion in out-of-pocket costs for people who would otherwise have been covered by Medicare.

Among the five million adults who would be directly affected by an increase in Medicare eligibility in 2014, nearly one-third (1.6 million) are estimated to pay less under their new source of coverage than they would have paid out-of-pocket under Medicare.[20] Yet two-thirds (3.3 million) are estimated to pay more as a result of shifting from Medicare to another source of coverage. **(Exhibits 3-6)**