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Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

June 11, 2014

Dr. Mark E. Miller
Executive Director
Medicare Payment Advisory Commission
425 Eye Street, N.W., Suite 701
Washington, D.C. 20001

Dear Dr. Miller:

Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Some have proposed that Post-Acute Care bundling reforms are premature and should not even be considered by Congress until such time as a standardized assessment tool is created and data collection is complete. Others have pointed to the fact that such perfecting of data collection could take a decade or more and even then, such an assessment will need to be refined. Do you agree with the notion that Congressional consideration of bundling should only occur after an assessment tool has been crafted and sufficient data collected or can both be done concurrently?

2. Medicare payments are a huge influence on the healthcare industry, often serving as a baseline for negotiations between hospitals and private insurers. Do private payers mimic Medicare site-of-service reimbursement disparities? Do private insurers obtain similar discounts for care that is provided through physician offices and Ambulatory Surgery Centers? Have any private insurers adopted site-neutral payment policies similar to the recommendation that MedPAC has made to Congress?

3. The respected journal *Health Affairs* recently released a study, finding that hospital ownership of physician practices is associated with higher prices and spending. Would you comment on how Medicare's payment differentials impact might have spillover effects to the private sector and health system?

4. Payment transparency is important for us to ensure that Medicare gets value for money. A 2013 GAO study found that 91% of hospitals receive upward payment adjustments relative to the standard Medicare fee schedule. Hospitals are also often exempt from state and federal taxes, and receive extra federal funding for uncompensated care costs. How much greater are price disparities between sites of service when these additional factors are taken into account?

5. Understanding CMS's impact as a payer on the shaping of our health care delivery system, I am concerned about the lack of communication and collaboration between the various payment staff at CMS. Do you believe that those with control over the various payment rules within CMS should be collaborating when putting forward payment rules that have the potential to shape the future of our health care system?

6. Do you think CMS should be required to provide an analysis of a rule's expected impact on other areas of the health care delivery system, including the impact on provider consolidation, as part of the analysis and transparency in their rule-making process?

7. We have had a number of hearings on the state of Medicare spending on how its current trajectory threatens access for future beneficiaries. MedPAC has suggested some reforms to address those concerns, including site-neutrality and Post-Acute Care bundling. Would you explain how important such reforms are for the future of the Medicare program and those looking forward to retiring into the program in future years?

8. In your report, examining potential ambulatory payment reforms, you talk about how seniors on Medicare can save money from reduced cost-sharing. Would you give me an example of that for an average senior?

9. If Congress did not adopt payment reforms that provided more site-neutral payments, how can we ensure seniors have better information to understand certain care settings may cost them more?

10. In your testimony, you raised issues related to the trend of hospitals purchasing physician practices, noting that it can increase spending by private plans and higher cost sharing. I understand that MedPAC has done some work in the past to estimate how much it costs Medicare to provide services in a hospital outpatient setting that could be offered in a physician office setting. Has MedPAC performed any follow-up work to examine how much provider consolidation might impact Medicare costs? How might some of MedPAC's recommendations regarding payments help minimize any potential cost increase associated with provider consolidation? Is there anything that can be done through more transparency in the claims process that could lead to further insights into the impact of provider consolidation on costs?

11. According to a Merritt Hawkins survey, the proportion of final year medical residents saying they would rather be employed by a hospital than work in other practice settings rose from 3% in 2001 to 32% in 2011. To what extent are Medicare practice expense payment disparities responsible for the decline in attractiveness of independent practice? How do these payment disparities compare with other factors driving the decline of independent practice?

12. Medicare payments are a huge influence on the healthcare industry, often serving as a baseline for negotiations between hospitals and private insurers. Do private payers mimic Medicare site-of-service reimbursement disparities? Do private insurers obtain similar discounts for care that is provided through physician offices and Ambulatory Surgery Centers?

13. MedPAC's March 2014 report states that "the lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. How important is risk adjustment to any proposal that Congress puts forward on bundling in the Post-Acute Care space?

14. MedPAC's 2014 report states that "there is no common patient assessment instrument used across Post-Acute Care settings." It has come to my attention that various industries can have proprietary feelings about their own tool and encouraging a common tool amongst the various provider types might be difficult. Does MedPAC have any suggestions as to how we might encourage the broad adoption of one tool? MedPAC has cited the use of the CARE tool as evidence of the type of common assessment tool that might be used in this space. Are there lessons from the CARE demonstration that might help educate Congress when considering legislation?

15. In any sort of legislative push toward bundling, data collection is key. Understanding how difficult quality measurement is in the area of rehabilitation and therapy, does MedPAC have any suggestions on ways to begin data collection and measurement? Are there certain focus areas under which data collection should begin like functional status for instance?

16. In its 2014 March report, MedPAC states "the Commission believes Medicare needs to move away from fee-for-service (FFS) payment and toward integrated payment and delivery systems to control unnecessary volume and enhance patient outcomes. How much unnecessary volume of inefficient care has MedPAC found exists in the Post-Acute Care space?

17. How might assessment, data collection, and quality measurement impact other areas of Medicare like Medicare Advantage or ACOs? Would such data collection help improve these differing models of care?

18. In MedPAC's March 2014 report, it states that the Commission has begun to develop outcome-based quality measures that are risk adjusted so that the efficacy of settings and services can be

evaluated. How long do you believe it will take the Commission to complete its work and how important will such measures be for future reform efforts?

The Honorable Michael C. Burgess

1. Outpatient hospital departments and ambulatory surgical centers have similar requirements to participate in the Medicare program and to be licensed at the state level, and both provide high-quality care for similar services, yet the reimbursement rates and fee schedule for each site are widely different. A large focus of the hearing was on the need for payment equity, with the general assumption that hospital reimbursement rates should be lowered to reflect those provided to other outpatient settings. What would the cost and benefit be for achieving equity through raising the reimbursement rate in certain outpatient settings such as ambulatory surgery centers while lowering the reimbursement rate in others? What impact would this have on hospital consolidation or expanded use of other outpatient settings? How would this affect patient access to care and costs overall?

2. The Medicare Program currently restricts certain kidney transplant recipients to 36 months of anti-rejection drugs. These Medicare beneficiaries require anti-injection drugs for the remainder of their lives. After the 36 month ends, these patients return to the significantly more expensive dialysis treatment. What are the cost implications for such a policy? Would expanding use of these drugs lower long-term costs for these patients who may need dialysis treatment and/or another kidney once coverage for these medications expires?

The Honorable Gene Green

1. The 340B Drug Pricing Program allows safety net providers access to discounted outpatient drugs so that they can continue to expand services offered to new and existing patients and to offset the costs of uncompensated care. However, some have raised concerns with the program, specifically in the context of outpatient oncology drugs between 340B outpatient hospitals and freestanding oncology clinics. Has MedPAC looked at the payment rates across 340B hospitals and non 340B hospitals for cancer drugs? Is so, could MedPAC comment on whether 340B hospitals get reimbursed at a higher rate than non 340B hospitals or community oncology practices for the drugs? Would you tell us about what analyses MedPAC might plan to do in this area?

The Honorable Mike Rogers

1. In your June 2013 report, you discuss the trend of hospital acquisitions costing Medicare more and driving up costs. The report discusses in great detail how this is happening in the cardiology space. Has the Commission seen this trend in other specialties, specifically the oncology space? If not, do you plan on it?

2. Has the Commission looked at what happens to patient access and costs with hospital acquisitions around different specialties? What are the benefits or costs to moving these patients into the hospital outpatient department?

3. In January of this year, the Commission voted on recommendations around site neutrality for 66 ambulatory payment classifications. Is the Commission looking at any other codes? Do you believe CMS will act on any of these recommendations in the upcoming HOPPS and MPFS rule?

4. If there was a level playing field in reimbursement in the outpatient setting, do you think that would stop or slow hospital acquisitions?

5. Have you thought about doing a single outpatient fee schedule? If so, how would you set that up? What would be the pros and cons to one outpatient fee schedule?

The Honorable Jan Schakowsky

1. MedPAC has noted a number of times that post-acute care providers enjoy some of the highest margins in all of health care. Would you briefly about the margins that post-acute providers like home health agencies, skilled nursing facilities, and others receive from Medicare payments? What does this tell you about Medicare's payment for these services? What recommendations do you have for how Congress should address these high margins?

2. MedPAC has noted substantial variation in utilization patterns and patient case-mix across for-profit and nonprofit post-acute care facilities. Would you discuss what is going on here and what implications facility ownership has for provision of services? Is this an issue Congress should be interested in?

The Honorable Gus Bilirakis

1. In the testimony of Dr. Brooks, he talks about how 1,338 community cancer centers have closed, consolidated or reported financial problems since 2008. This would seem to be a disturbing trend. Has MedPAC noticed a pattern of decreased community oncology centers and an increase in hospital outpatient cancer services?

2. If community oncology practices close, diminish, or reopen as a Hospital Out-Patient Department, will this have a corresponding increase in Medicare spending because of the higher payment schedule? If so, do you have an estimate of how much?

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. I frequently hear from hospitals and physicians saying that the reimbursement rates for Medicare do not cover their costs sufficiently. But based on a number of reports, it appears some providers are also making money on the 340B program. Has MedPAC done any work examining this as another payment disparity between different types of providers at different sites of service? What considerations are relevant for Congress on this issue?

2. We have heard concerns about people without insurance or who have Medicaid and what their outcomes look like compared to individuals with private insurance. For example, the survival rates are very different for people with different coverage who have cancer. But, according to the Cancer Medicine Journal, it is due to a complex set of demographic and clinical factors, of which insurance status is just a part. But I want to look at this in terms of Medicare, based on where a person actually gets their care: a hospital base compared to a physician's office. Are you aware of any clinical literature, or has MedPAC done any work, examining the differences in medical outcomes or survival rates based on where the care was delivered?