

**QUESTIONS FOR THE RECORD
COMMITTEE ON ENERGY AND COMMERCE -- HEALTH SUBCOMMITTEE
MAY 21, 2014**

**TESTIMONY BY MARK MILLER, Ph.D.
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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?**

Answered in testimony. See transcript.

- 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?**

Answered in testimony. See transcript.

- 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?**

Answered in testimony. See transcript.

- 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?**

It is very difficult to account for the factors cited above, given the wide variation across providers in the amount and type of tax exemptions and payment adjustments received. Non-profit hospitals and non-profit systems employing physicians are exempt from state and federal corporate taxes, but for-profit hospitals are not. Disproportionate share hospitals receive uncompensated care payments, but those serving smaller shares of poor patients do not. Physicians pay personal income taxes, but may avoid corporate state and federal income taxes by forming an S-corporation or a limited liability company. In the outpatient payment system, Medicare adjusts payments upward for all services provided in sole-community hospitals by a uniform rate, but this is offset by lower payments to all other hospitals to make the policy budget neutral. Given these complications, we do not have sufficient data to calculate price disparities that account for the factors you describe. We can say that the current difference, even prior to making these adjustments, is substantial and can distort the market for these services.

- 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?**

The Commission has long been interested in moving away from fragmented, silo-based delivery systems, and has recommended payment reforms that would encourage more efficient, coordinated care focused on the needs of the patient. Such reforms include setting site-neutral payments for similar services provided in different settings and implementing a standardized assessment tool for all post-acute care settings. If the Congress were to decide to enact those recommendations into law, it would seem appropriate to have relevant CMS staff from each of the affected provider payment areas involved in the policy development to ensure that such reforms are well developed and do not have unintended consequences for the Medicare program or the broader health care delivery 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?**

When the Commission evaluates proposed changes to Medicare's payment systems, to the extent feasible it reviews the effect of such policies on beneficiaries and providers, as well as on the delivery of health care services more broadly. However, due to data limitations, it is not always possible to estimate the impact of a proposed change on all aspects of health care delivery. If CMS were able to conduct such analysis in its rulemaking process, it could inform the Congress and other stakeholders' comments on proposed rules, but it may not be feasible in all instances.

- 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?

As you note, the Commission has recommended that Medicare make comparable payments for similar services regardless of where the services are provided. This policy concept is based on the principle that a prudent purchaser would obtain care in the lowest-cost setting where safe, high quality care is provided. In many cases, the Medicare patient benefits, since a lower Medicare payment to a provider may also mean a lower beneficiary copayment (as would be true in the case of equalizing payments for certain services between hospital outpatient departments and freestanding physician offices). In addition, lower Medicare payments help to preserve the sustainability of the Medicare trust fund into the future.

The Commission also supports ongoing testing and implementation of new payment models that promote care coordination while discouraging unnecessary utilization and excessive payments. Payment models that require providers to be accountable for an entire episode of care have the potential to reduce spending and improve care. Implementing policies that achieve the twin goals of better care and lower spending will be critical to preserving the Medicare benefit for future generations of beneficiaries.

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?

For level 2 echocardiograms (ambulatory payment classification number 269), the beneficiary's copayment is \$98.36 if it is provided in a hospital outpatient department, but only \$45.60 if it is provided in a physician's office. The copayment is 116 percent higher in OPDs than in physicians' offices. Under our recommendation, the copayment in OPDs would decline to \$45.60.

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?

There are several ways to educate beneficiaries about the differences in cost sharing they may face in different settings. For services that can be provided in both physician offices and OPDs, the Congress or CMS could require physicians and other practitioners to inform their patients that it is more costly to receive care in OPDs than in freestanding offices. Medicare could also make this information available to beneficiaries through notices sent in the mail or posted on the Medicare Hospital or Physician Compare websites.

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?

By provider consolidation, we assume you mean hospitals acquiring physicians' practices or ASCs. This trend has resulted in services migrating from less costly settings (e.g., freestanding physician offices) to more costly settings (e.g., hospital outpatient departments). For example, in 2012 Medicare saw a 7% drop in the volume of echocardiograms provided in the physician office setting and a 13% increase in the same services provided in hospital outpatient departments. The impact of the migration of this and other services on program and beneficiary spending is significant. We estimated that Medicare pays approximately \$2 billion more annually for services that are provided in the hospital outpatient department that could reasonably be provided in the freestanding office, and recommended that Medicare hospital outpatient department payment rates for these services be reduced. The Commission's recommendations on equal payments across settings can mitigate spending increases that result from provider consolidation, because payments for some services that have migrated to the higher cost outpatient department would be reduced.

Currently, Medicare lacks data that directly shows provider consolidation because the data on physician practices that have been purchased by hospitals and converted to provider-based status are very poor. To produce this type of data, Medicare could require providers to indicate on claims when a service is provided in an off-campus department that has provider-based status. CMS has proposed doing so in a recent notice of proposed rulemaking.

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?

We have identified three factors that have likely contributed to the decline in how attractive independent practice is to medical residents. These include:

- An increase in the cost of running a practice.
- A desire for a different work-life balance and more lifestyle flexibility.
- A financial benefit from being employed by a hospital over owning your own practice.

It is very difficult to disentangle how much each of these trends has contributed to residents' opinions about owning their own practice because they have occurred at the same time.

- 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?**

Answered in testimony. See transcript.

- 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?"**

Risk adjustment is key to making valid comparisons across patients and providers. Without it, providers may appear to be inefficient or high cost, or to furnish lower quality of care or have worse outcomes when in fact they treat sicker patients. The lack of comparable information also undermines our ability to examine whether certain providers or settings selectively admit certain types of patients and avoid others. Comparable information will also help beneficiaries and their caregivers make accurate comparisons in selecting a setting or provider.

As Medicare moves towards value-based purchasing and broader payment reforms (including bundling), comparable information is critical to evaluating a provider's or a setting's mix of patients, costs, and outcomes. If the approach to bundling includes a target payment or benchmark, it will be important to risk adjust the provider's actual payments for the severity of the mix of patients it treats. Otherwise, a provider could be unfairly penalized or rewarded based on its mix of patients.

In addition to assisting us with risk adjustment, comparable information about patients in the different PAC settings can also enable Medicare to set payments more accurately across settings. For example, Medicare could consider narrowing the payment difference between skilled nursing facilities and inpatient rehabilitation facilities for certain conditions that are frequently treated in both settings. Setting payment rates more accurately would help when developing bundling proposals because it would provide a more precise set of input prices when determining how to pay for the entire bundle of services.

- 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?

Minimizing providers' administrative burden is an important factor in encouraging the adoption of common assessment items. The common assessment items could be added as a supplement to existing assessment tools for SNF, IRF and home health care, minimizing the impact of adopting common measures (it would be a new data collection tool for LTCHs as they currently have no required patient assessment instrument). Most of the existing tools would remain in place, significantly reducing the work needed to master the new items. The common items could be phased in over time, which would allow providers more time to conduct transition activities. The initial set of common assessment items should include a limited number of select items from key domains that are important for adjusting outcomes and payments for patient differences. These items should include functional status, cognitive status, and the provision of special services (such as ventilator care or intravenous drugs). CMS could retire the existing items on the required assessment tools once sufficient data had been collected to permit the use of the common assessment items for payment and quality measurement.

A number of training and support activities were conducted as part of the CARE demonstration, but we are unaware of any analysis of these efforts. The experience of the CARE demonstration suggested that providers from all settings could be trained to accurately use a common set of assessment items. Proper support is essential for ensuring that providers understand assessment requirements. CMS may want to review its past efforts to educate providers and the implementation of the existing assessment tools to identify best practices for use in implementing any new common assessment items.

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?

The Commission has recommended that the initial set of common assessment items should include functional status, cognitive status, and the provision of special services such as ventilator care or intravenous drugs. These items could be added to the existing assessment tools, and replace them as soon as practicable. These items would facilitate comparisons of resource use and quality, and support the development of a common case-mix system. Additional items could be implemented in later years, covering other areas such as the availability of a caregiver in the patient's home.

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?

In the Commission's 2011 report on geographic variation in Medicare spending we reported that the variation in the use of post-acute care was greater than for other services. For example, the area at the 90th percentile had spending that was two times the spending found in the area at the 10th percentile. At the extremes, the differences are even larger. For example, home health spending in Miami-Dade county in 2008 was more than 15 times the spending in a neighboring Florida county. It is difficult to categorize how much of this care is inefficient, but the analysis suggests that significant savings could accrue if higher-spending areas could reduce their utilization. Payment models that better reward efficiency, such as ACOs or bundling of inpatient and PAC, could be a means for lowering PAC use in high spending areas. Medicare's fee-for-service payment systems reward additional volume, contributing to the wide disparity in spending among areas.

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?

The collection of comparable information will benefit all models of care delivery – FFS, ACOs, and MA. In addition, we expect the information to have benefits for beneficiaries, providers, and the Medicare program.

Beneficiaries – whether in traditional FFS, ACOs, or MA plans – stand to benefit from this data collection because they will be able to incorporate information about quality into their decisions about where to seek care.

Comparable information would also allow ACOs and MA plans to select high-quality, efficient providers as preferred or “in-network,” and to use the information to evaluate provider performance in renewing the providers in their networks.

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 Commission is considering a new approach to measuring and reporting on the quality of care within and across the three main payment models in Medicare: FFS, MA, and ACOs. This quality measurement approach would deploy a small set of population-based outcome measures (such as potentially preventable hospital admissions, potentially preventable ED visits, and patient experience measures) to assess the quality of care in each of the three payment models within a local area.

The Commission's vision is that over the next several years, Medicare would move away from publicly reporting on dozens of clinical process measures and toward reporting on a

small set of population-based outcome measures for the beneficiary populations served by FFS Medicare, ACOs, and MA plans. By focusing on meaningful quality measures, Medicare could improve value for the beneficiary and the taxpayer and reduce administrative burden on providers.

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?**

The Commission has specifically examined the differences in payment rates between ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs). In the Commission's June 2013 Report to the Congress, we identified 12 sets of services that met our criteria for equal payment across OPDs and ASCs. Payment rates for ASCs are less than those for OPDs; the 2013 ASC conversion factor was approximately 60 percent of the outpatient conversion factor. We estimated that reducing OPD payment rates to the ASC level for these 12 APCs would reduce program spending and beneficiary cost sharing by a total of about \$590 million in one year.

We did not examine the effects of raising ASC payment rates while lowering HOPD rates. Depending on how the policy is structured, hospitals' incentives to consolidate or acquire other providers would decline, and they would likely reduce their volume, which could reduce program spending in that sector. Existing ASCs might expand and new ASCs could enter, which might increase volume and program spending in the ASC sector. Therefore, the net effect on overall volume and program spending is ambiguous. Furthermore, beneficiaries are currently receiving these services in ASCs, which suggests that ASC payment rates are high enough to assure access to these services. Therefore, setting site neutral rates higher than current ASC rates would result in Medicare payment rates that are higher than needed to protect access to care.

In all of our analyses on this issue, we emphasize that payment rates should be higher in OPDs for some (but not all) services when patient needs differ between hospitals and freestanding offices. For some services and for some patients, the standby emergency capacity offered by hospitals is necessary to assure patients' safety. Therefore, making payment rates for all services equal across ambulatory sectors has the risk of compromising patients' safety and should be avoided.

- 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 1972 amendments to the Social Security Act extended Medicare benefits to people with end-stage renal disease (ESRD), including those under age 65. The Omnibus Budget and Reconciliation Act of 1986 provided coverage of immunosuppressive drugs furnished within one year of an individual's Medicare-covered transplant. Under the Omnibus Budget Reconciliation Act of 1993, immunosuppressive coverage was gradually extended from 12 months following a covered transplant to 36 months. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) effectively eliminated the 36-month time limitation for immunosuppressive coverage for Medicare beneficiaries age 65 years and older and the disabled. The Congressional Budget Office estimated that the cost of this BIPA provision was \$0.1 billion in 2001 and \$1.4 billion over the 2001-2010 period. The Commission has not analyzed the potential cost of a policy to extend lifetime coverage of immunosuppressive medications to all beneficiaries, including the non-elderly, non-disabled.

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 340 B 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 Commission has recently begun analysis of the 340B program to understand how it functions, its growth in recent years, and its implications for Medicare. At this time, we do not have the answers to your questions. We expect to begin discussing this work publicly in the fall of 2014 and preliminary results will be shared with the Congress as the work is discussed at Commission public meetings.

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?**

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?

We have not examined the effect of hospitals acquiring practices on patients' access and cost with regard to specific specialties. For services that can be safely provided in freestanding offices and for which beneficiaries' access is adequate, there is no benefit to patients in moving these services to OPDs, and it increases program spending and beneficiary cost sharing.

However, in our analyses we emphasize that it is safer to provide some services in OPDs than in physicians' offices. Therefore, we limit our recommendations on equal payment rates across settings to services that we believe can be safely provided in freestanding offices and where patient severity is no greater in OPDs than in freestanding offices.

- 2. 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?**

The Commission identified the 66 sets of services using criteria to determine when it would be appropriate to equalize or narrow payments between ambulatory care settings. If other services met those criteria, Medicare could consider expanding the site neutral policy to those as well. However, CMS does not currently have the authority to implement our recommendation; doing so would require a change in law.

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

If there is a level playing field in terms of payment in outpatient settings, we believe it would reduce hospitals' acquisition of physicians' practices. However, the extent of that reduction is unclear because other incentives still exist:

- Specialists who perform their services at hospitals may provide a reliable source of tests, admissions and referrals for their hospital.
- Accountable care organizations give hospitals incentives to acquire physicians' practices.

- Acquisition of physician practices may give hospitals greater leverage in private payer payment negotiations.

4. 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?

There may be reasons to maintain some differences in Medicare payment rates across sites of care. For many services, what is provided in hospitals is different from what is provided in freestanding offices. For these services, payment rates should be different between settings. The reasons for these differences include:

- Some services require the existence of standby capacity for handling emergencies.
- For some services, hospitals have sicker patients who may be more costly to treat.
- For many services, the outpatient payment system packages ancillary items with primary services to a greater degree than does the physician payment system. This additional packaging makes the services provided in OPDs appear more costly.

To the extent these issues are applicable, the payment rate in the outpatient payment system should be higher than the rate in the physician payment system.

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 comment 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?

For more than 10 years, Medicare margins have exceeded 10 percent for home health agencies (HHA) and skilled nursing facilities (SNF). Inpatient rehabilitation facility (IRF) margins have declined from a high of 17.7 percent in 2003 but have remained above 8 percent since then. Long-term care hospital (LTCH) margins have been positive throughout this 10-year period but more variable, first rising to almost 12 percent in 2005 and then settling in the 6 to 7 percent range since 2009.

In 2012, the average Medicare margin for the 4 PAC settings was:

- HHA: 14.4%
- SNF: 13.8%
- IRF: 11.1%
- LTCH: 7.1%

These relatively high Medicare margins indicate that payments are more than adequate to cover the costs to treat Medicare beneficiaries. The reasons for these margins vary

slightly by sector. In the home health sector, payments are based in part on the assumption that providers will make a certain number of home visits per 60-day episode, but in reality, providers have a lower rate of visits per episode than assumed. HHAs have also been very successful at keeping their cost growth below payment updates. In the SNF sector, payments are based in part on how much therapy is provided to beneficiaries. Over time, SNFs have increasingly provided more therapy to beneficiaries, thereby qualifying for higher payment categories. Though the provision of more therapy raises costs, payments rise even faster, resulting in higher margins for higher therapy case-mix groups. For IRFs and LTCHs, larger facilities and those that controlled their costs have higher margins than other facilities.

MedPAC has made several recommendations to lower and better target Medicare's payments. For SNFs and HHAs, the Commission recommended eliminating the payment update and rebasing payments to better align payments to costs. To better target payments, the Commission recommended redesigning the prospective payment systems to base payments on beneficiary characteristics, rather than the amount of therapy provided. In March 2014, the Commission recommended reserving the LTCH payment system for chronically critically ill patients and using the acute hospital payment system for less complex patients.

- 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?**

There is variation in practice patterns across PAC settings by many factors, including ownership. In any setting, smaller facilities, which tend to be nonprofit, may benefit less from economies of scale. For-profits are more likely to be members of large chains and therefore may have more control over their input costs (e.g., volume-related discounts). Members of chains that own other types of PAC providers may have an advantage because they may be better able to control mix of patients and their lengths of stay.

In SNFs, for-profit facilities, urban facilities, and freestanding facilities tend to have higher shares of days assigned to the highest rehabilitation case-mix groups compared with other facilities, though the differences have gotten smaller over time. The increasing share of patients assigned to rehabilitation case-mix groups and, within those, the share assigned to the most intensive therapy case-mix groups, points out a fundamental problem in the prospective payment system (PPS). The PPS encourages providers to furnish more therapy as a way to boost payments. The Commission recommended revisions to the design of the SNF PPS in 2008 and, although CMS has made many changes to the PPS, this inherent bias remains. Given the bias of the PPS, beneficiaries with medically complex conditions could face impaired access to SNF care in some markets.

Among HHAs, for-profit free-standing agencies typically provide more of the highest-paid therapy services than non-profit or facility-based agencies. Similar to SNFs, the home health PPS makes higher payments for episodes with more therapy visits. This

encourages providers to deliver more visits when possible, and to avoid patients that do not require these services. The Commission recommended in 2010 that Medicare eliminate the number of therapy visits provided in an episode as a payment factor. CMS has made several changes to reduce the incentive to manipulate therapy visits to increase payment, but more visits in an episode still produce higher payments. Implementing the Commission's recommendation would eliminate this vulnerability, and safeguard access to care for patients that have care needs other than therapy.

Among IRFs, for-profit providers are disproportionately freestanding facilities rather than hospital-based facilities. Freestanding facilities tend to be larger, and therefore benefit more from economies-of-scale. Freestanding providers have also been more successful at containing their costs in recent years. As changes in the compliance threshold (the so-called 60% rule) resulted in lower patient volumes and higher severity of illness in IRF patients, freestanding facilities may have been more successful at containing costs across all components because of financial necessity among the stand-alone and predominantly for-profit facilities.

For LTCHs, in addition to the trends noted above, for-profit facilities have fewer short-stay outliers (SSO), possibly because they are selecting patients who will require longer stays or managing length of stay to ensure patients stay long enough to trigger a higher Medicare payment. Nonprofits have more high-cost outliers, but it's not clear whether this is due to differences in efficiency or case complexity or both.

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?**

To date, we have not tried to analyze such a pattern. However, each year we monitor changes in volume and setting of health care services for Medicare beneficiaries, as well as beneficiary access to physician services, and report those findings to Congress in our March report.

- 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?**

The closing of community cancer centers could result in billing of oncology services shifting from freestanding offices to OPDs. To the extent that OPD rates are higher than rates in physicians' offices, Medicare spending would increase. We do not have an estimate of the effect of a shift of oncology services from community practices to OPDs on Medicare spending.

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?**

The Commission has recently begun analysis of the 340B program to understand how it functions, its growth in recent years, and its implications for Medicare. At this time, we do not have the answers to your questions. We expect to begin discussing this work publicly in the fall of 2014 and preliminary results will be shared with the Congress as the work is discussed at Commission public meetings.

- 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?**

MedPAC has not done any analysis comparing differences in outcomes between ambulatory settings, and we are not aware of any literature that examines this issue. Because of the variation in the types of services provided in ambulatory settings (e.g., office visits, procedures, tests) and the limited clinical information reported on Medicare claims, it would be difficult to define relevant clinical outcomes for patients in these settings.