

Chairman Frank Pallone, Jr.
Subcommittee on Health Hearing
MedPAC's June 2010 Report to Congress: Aligning Incentives in Medicare
June 23, 2010

Good afternoon. Today the Health Subcommittee is meeting to hear about the Medicare Payment Advisory Commission's (MedPAC) June 2010 Report on Aligning Incentives in Medicare. Let me begin by welcoming to the Subcommittee Mr. Glenn Hackbarth who currently serves as Chairman of the Commission and will be the only witness testifying before us today. Thank you for being here today Mr. Hackbarth.

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

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

Take for example, the first chapter of this year's report, which examines opportunities to enhance Medicare's ability to innovate. The report notes that the Secretary of Health and Human Services (HHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) need greater flexibility to implement innovative payment, coverage and delivery system reform policies in Medicare.

As the Commission's report correctly points out, as part of the Patient Protection and Affordable Care Act (PPACA), Congress authorized the creation of a Center for Medicare and Medicaid Innovation within CMS. In addition, the new health reform law improves the flexibility that HHS and CMS have over Medicare by:

- simplifying the demonstration approval and implementation process within CMS;
- authorizing new funding for CMS to carry out important new demonstrations that will improve quality and lower health care costs;
- and creating a new process by which the Secretary of Health and Human Services can expand successful demonstrations without further Congressional approval.

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

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

It is clear to me that there is a lot of correlation between some of the recommendations made in this month's report and some of the initiatives that were included in the new health reform law. But the

Commission's new report also seeks to examine other opportunities for the Congress to improve the Medicare program.

For example, the Commission takes a fresh look at the way Medicare funds Graduate Medical Education (GME) in this country and makes recommendations on how to improve it. The Commission also looks at the growth of payments for in-office ancillary services, an issue that they have examined in the past. However, this year, instead of simply looking at how physician behavior is adding to the growth in these services, MedPAC also looks at the role beneficiaries play in driving up the volume of these services.

I am anxious to hear about MedPAC's research and recommendations in these areas, but I also think that we need to proceed carefully. I have concerns and questions that need to be answered. For example, what would the impact of your recommendations on GME be on the teaching hospitals that rely heavily on these funds. Can hospitals that operate on very slim margins or in the red, like those in my state of NJ, continue to operate and provide the same level of services if they begin to lose GME funding?

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

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

Before the Memorial Day recess, the House passed a bill that would provide another temporary reprieve to physicians by delaying that cut from being imposed and replacing it with a modest increase through the end of 2011. Our colleagues in the Senate have advocated for a shorter term pared down package and we have been unable to find agreement up to this point. We all realize the need for swift action.

The Democrats and Republicans in the House and Senate, as well as the physician community need to work together to develop a permanent fix to this problem that has vexed all of us for far too long. We simply cannot continue to kick this can down the road and allow uncertainty for our Medicare providers and beneficiaries.

Thank you and I now recognize our Ranking Member, Mr. Shimkus, for five minutes for the purpose of making an opening statement.