

**Hearing on the President's and Other Bipartisan Proposals to Reform Medicare
Post-Acute Care Payments**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

June 14, 2013

SERIAL 113-HL05

Printed for the use of the Committee on Ways and Means

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Hearing on the President's and Other Bipartisan Proposals to Reform Medicare Post-Acute Care Payments

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:29 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the subcommittee] presiding. [Advisory](#)

Chairman [Brady](#). Good morning. The subcommittee will come to order.

And I want to welcome everyone to today's hearing on bipartisan proposals, including those in the President's budget, to reform how Medicare pays for care after patients are hospitalized.

This is the fifth hearing for our subcommittee this Congress and the fourth in a series focusing on bipartisan proposals to reform Medicare and Social Security. I am proud to say that today's effort is truly a bipartisan hearing, that the Ways and Means Health Subcommittee staffs from both majority and minority staffs have collaborated on this hearing.

Today's discussion focuses on reforming how care delivered after a hospitalization in the Medicare program is paid for. We will focus on five policies from the President's 2014 budget that are also supported by several bipartisan organizations.

Our goal is to discuss the details around the following specific policies: one, reducing Medicare market basket updates for home health, nursing homes, rehab hospitals, and long-term-care hospitals; creating site-neutral payments between hospitals and nursing homes; establishing more stringent criteria for rehab hospitals; tackling readmissions from nursing homes; and creating bundled payments.

The President's budget estimates these five policies will save \$93 billion over 10 years, and CBO estimates these policies would save less, \$54 billion. These are real savings, in any case, for a program that is facing bankruptcy in just 13 years.

The topic for today's hearing was chosen, in part, from listening to my colleagues. Mr. McDermott, during our last hearing, suggested that we may be cherry-picking proposals from the President's budget that only focus on beneficiaries. Though we still firmly support redesigning the Medicare benefit, we know it is only one factor in the Medicare program that needs reform, and we should look at other items in the President's budget.

Today we are exploring after-hospitalization care because it is in desperate need of reform. It has been over a decade since Congress has made meaningful changes to the way after-hospitalization care is reimbursed.

While we recently received some good news from the Medicare Trustees Report, which noted the life of Medicare's main trust fund was extended by 2 additional years, I think some additional perspective is necessary. To me, 2 years is equivalent to the Titanic hitting the iceberg an hour later. We are still in deep financial trouble for this very important program.

So I challenge this committee and our witnesses today to think bolder. A question we should be asking ourselves is, how can we extend the life of Medicare for an additional 10 years? An additional 20 years? Perhaps an additional 30 years? Because we owe it to current and future seniors to meet these goals. These will require hard decisions, but making them now will ensure a vibrant Medicare for generations to come.

Before I recognize Ranking Member McDermott for the purposes of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

Without objection, so ordered.

Chairman Brady, I now recognize Ranking Member McDermott for his opening statement.

Mr. McDermott, Thank you, Mr. Chairman. I appreciate your willingness to approach this topic on a bipartisan basis because I suspect there is quite a bit we agree on.

Post-acute care is really a broad clinical term for all the activities that come after the acute incident or acute hospitalization. Their health is stable and the question is, what do we do with you now? It is something everyone in this room will have or has had at some point a chance to deal with. It can be messy. It is sometimes the road to the end.

My experience with my parents living to 97 and 93 is I had quite a bit of time to operate in this area. And when I came to Congress, there was a group of about nine of us who would meet at the back of the floor when we got off the plane from the West Coast and discuss our experiences over the weekend of dealing with the problems of our parents' post-acute care.

And there is no manual for this. You find yourself stumbling around, trying to navigate a system, while you watch someone you love declining. We all want the same thing for our parents and any other loved ones who we have in this situation; it is the best care possible. We want them to have the highest quality we can get for them, but we also want it to be efficient. So when we talk about reform, we have to remember the people behind it.

This sector has a lot of challenges. Double-digit inflation margins in several post-acute settings indicate that Medicare payments far exceed costs. Some parts of the country -- it is true, 10 years ago, I remember a hearing just like this on this issue -- had unusually high use of post-acute care. So there are concerns about utilization patterns and, certainly, fraud.

Providers operate in silos, creating disincentives to coordinate care and improve transitions between settings. And I am sure our witnesses will talk more about this, so I am not going to belabor the point.

We can be happy that the Affordable Care Act has put Medicare on a path toward post-acute reform. CMS is now testing the concept of bundled payments, which could break down the silos and encourage better-coordinated and more efficient delivery of care.

Providers are starting down the path toward value-based purchasing with pay-for-reporting and demonstration projects to test that concept. The ACA has also provided new fraud tools to weed out the unscrupulous providers and took steps to recoup and rein in overpayments.

But more can and will have to be done. Right now, there are billions of dollars of savings that can be had by further reconfiguring payments to better match actual costs. And that will help us address the extremely high Medicare margins of post-acute providers.

Now, the real savings that will go toward a Medicare physician fix rather than loading more costs onto beneficiaries with incomes of \$22,500 is really, I think, what we have to begin thinking about. We can also find longer-term reforms, and I look forward to hearing these ideas from CMS and from MedPAC.

While there are a whole lot of interesting concepts and policy in this arena, we need to learn from the A.C. efforts under way. We have put them in motion, and we are now watching them. I don't think we should move too quickly, because we need to let them see if they really work to ensure that models work in a way that doesn't compromise access and provides high quality for our beneficiaries.

And then, finally, as Chairman Brady did, I would like to address something that the majority has raised. While we agree on the need for post-acute reform and much of the problem, I have to take issue with the notion that Medicare is broke and that post-acute reform is the simple fix. There is no simple fix to the question of increasing health care.

The Supreme Court made a decision yesterday that there is no ability to patent genes. And what gene therapy is going to do over the next 20 years, it is impossible for us to sit here today and predict. Nobody predicted where Medicare would be today 20 years ago or 40 years ago because medicine has advanced, and it is simply impossible to have any kind of system where you have it funded out there for 20 or 30 or 40 years.

Reform is a worthy goal in and of itself, but let's not cloak it in alarmist rhetoric about the program's finances. Medicare's finances are strong. The trustees just announced the solvency, as you heard, is extended by 2 years. Medicare spending per beneficiary -- per beneficiary -- grew at the low rate of 1.7 percent from 2010 to 2012. And projected spending growth will continue to be slower with the overall economy.

So let's agree that changes to the post-acute system are needed, that we can improve quality for our parents and loved ones as well as rein in overpayments. We don't need hyperbolic statements to motivate to us action. We need to do it for our families.

I yield back the balance of my time.

Chairman Brady. Thank you.

Chairman Brady. Today, we will hear from two witnesses: Jonathan Blum, deputy administrator and director of the Center of Medicare at the Centers for Medicare and Medicaid Services; and Mark Miller, executive director of the Medicare Payment Advisory Commission.

Thank you both for being here, and I look forward to your testimony. You will both be recognized for 5 minutes for the purposes of providing your oral remarks.

Mr. Blum, we will begin with you.

Mr. Blum, Chairman Brady, Ranking Member McDermott, members of subcommittee, reforming Medicare's post-acute-care policy should be one of our highest priorities to improve the delivery of care and to reduce overall costs of the Medicare program. We thank you for the opportunity to offer our thoughts and perspectives.

Payment for Medicare post-acute-care services has challenged the program for many, many years. Patients with similar needs overlap the current silos of post-acute care. We don't have a great definition for what constitutes a SNF patient or an LTC patient, for example. We don't know what the right mix of post-acute-care services are for a given condition. As a result, post-acute care is one of our fastest-growing areas.

Over the past several years, CMS has spent much time analyzing geographic differences in health spending and outcomes, particularly for the Medicare fee-for-service program. Our work complements efforts performed by the Institute of Medicine, the Dartmouth Atlas, and MedPAC.

While there are many drivers for these spending differences, several conclusions are clear to us.

One, what really drives differences in Medicare fee-for-service spending is what happens to the patient after he or she leaves the hospital. For example, for a 30-day episode of care for a common heart procedure, the costs across the country can vary by a factor of two to one, with the differences being driven by the degree of post-acute-care services provided and whether there is a high probability for a hospital readmission.

Two, higher quality of care is not associated with this degree of higher spending in some areas of the country. For example, high overall spending levels of post-acute-care services are not correlated with lower hospital readmissions. Despite some arguments from the industry, more spending on post-acute-care services over current levels will not necessarily reduce spending in other healthcare channels. Indeed, many of our highest-performing areas of the country, in terms of quality and cost, use relatively few post-acute-care services following a hospital stay.

In short, we have to pay for post-acute-care services in a better way to improve the quality of care and reduce overall costs. Developing these better payment policies will require a combination of interventions and approaches.

Over the long term, we are hopeful that our new payment approaches and pilot programs will lead to new care-delivery models that better integrate post-acute-care services with hospital services and community services to better manage patient transitions and episodes of care. For example, we are in the process of implementing four bundled payment models. Two of them will have a distinct focus on aligning financial incentives of post-acute-care providers with the overall cost of care. We are confident these models will lay the groundwork for a permanent payment policy.

We also believe that a key success factor for our more than 250 ACOs, or accountable care organizations, will be to establish better models for delivery of post-acute-care services. However, while we establish new models of payment and delivery, we also believe that we must take incremental but forceful steps to make our current payment systems more accurate and to ensure that post-acute-care providers treat patients that are most appropriate for their care setting.

Over the past several years, we have made changes to our post-acute-care payment systems to rebalance them to have stronger incentives to care for the sickest patients. We have taken significant steps, some required by the Affordable Care Act, to reduce spending where there is clear evidence the program overpays relative to the cost of care.

And we have also put in place new requirements to ensure that benefits are being provided consistent with clinical need and care planning. For example, beneficiaries now receiving home health benefits must be seen by a physician in a face-to-face encounter to better ensure the integrity of the service.

This year's President's budget also proposes some additional changes that we feel are very important to achieve the President's goal of reducing Medicare spending by about \$371 billion over the next 10 years without compromising the quality of the care the program provides.

Given the current growth trends and Medicare post-acute-care payments, we believe it is very important to take more steps, but careful steps, to further reduce spending to ensure these payment systems remain sustainable while better serving our beneficiaries.

I would be happy to answer your questions.

Chairman Brady. Thank you, Mr. Blum.

Chairman Brady. Mr. Miller, you are recognized.

Mr. Miller. Thank you.

Chairman Brady, Ranking Member McDermott, and distinguished members of the subcommittee, I would like to thank you for asking the Commission to testify here today.

MedPAC's work in this area has been guided by three objectives: to assure that the beneficiary gets high-quality, coordinated care; to protect taxpayers' dollars; and then to pay providers in a way to achieve those two goals. MedPAC has been trying to move the payment systems away from fragmented fee-for-service that encourages volume growth and discourages coordination toward systems that focused on payment and delivery that are organized around patient need.

But post-acute-care reform is difficult. There are few clinical guidelines regarding the services that are necessary, and as you have already heard, there are wide variations in the utilization of services. For example, in McAllen, Texas, there are seven times more home health services per person than the national average. In Miami, there are five times more home health services than the neighboring county.

Related to that, there is not a uniform way to assess patient needs or outcomes. Some of our payment systems require a common assessment instrument, but they are different in each setting, and we cannot compare outcomes and needs across setting. And some settings don't have an assessment instrument. This is extremely important. It encumbers the process of linking payment to quality and the process of developing a more rational payment system.

Another issue is that providers select the patients they care for. And on the one hand, this really makes sense; you want to pair up patients with providers who can provide the necessary care. But in our payment systems, this means providers can select patients for financial reasons. We believe that, over time, certain SNFs in home health, skilled nursing facilities, and home health agencies, have focused on basic rehab patients and avoided medically complex patients because the former are more profitable than the latter.

As Jon has mentioned, we pay different rates for similar services and similar patients. This creates incentives to move patients across payment systems, involving unnecessary transitions and additional costs. For example, long-term-care hospital payments are generally higher than acute-care hospital payments for the same patient, but a recent analysis suggests that as many as 50 percent of the patients in long-term-care hospitals could be treated in different settings.

If you think in terms of time frames, MedPAC's efforts in the past and in the short term have been focused at improving fee-for-service and encouraging movement to better systems. This involves reforming the underlying payment system to pay providers fairly; limiting and reducing payment rates to protect beneficiaries out of pocket, and the taxpayer; expanding program integrity to focus on bad actors; and linking payment to quality.

Let me illustrate a couple of these principles. The underlying skilled nursing facility payment system, as I have mentioned, encourages providers to take basic rehab patients and avoid medically complex patients. We have recommended changes that would pay the provider more accurately based on the patient that they take.

We also believe that the original base rates for skilled nursing facilities were set too high, and this has contributed to very high profit margins for more than a decade, currently running about 14 percent. We have recommended reducing the payment rates to be more consistent with the level of effort.

Now, if you think about these two ideas together, this allows you to lower the rates but not to harm the agencies that are taking the most complex patients. We have made similar recommendations for home health.

In the near term in order to encourage a more coordinated system, we have called for a unified assessment instrument that can be used to assess the patient regardless of what setting they go to. We have recommended for skilled nursing facilities with excessive readmission rates back to the hospital. And we have just begun our discussions of a site-neutral payment system for long-term-care hospitals and acute-care hospitals, but those discussions have just begun.

In the long run in order to move to more fully coordinated care, we have recommended demonstrations to bundle payments around hospitalizations and post-acute care. And we have given extensive guidance to both Congress and the CMS on the design and implementation of two-sided risk accountable care organizations.

In closing, I think what the Commission is looking for is a post-acute-care system with a unified patient assessment instrument, a payment that matches resources to needs, but puts the provider at risk for unnecessary services, but then clears out unnecessary fee-for-service rules to allow that provider to determine the ideal mix of post-acute-care services.

Thank you for your attention. I look forward to your questions.

Chairman Brady. Thank you, Mr. Miller.

Chairman Brady. To both of you, the last time Congress mandated comprehensive reform of Medicare payments was in 1997 with the Balanced Budget Act. We are considering changes and reforms to extend the life of Medicare similar or greater in magnitude to those reforms. Many believe Congress took reform too far in 1997 and consequently gave back some of those reforms in 1999 and beyond.

So a broader question in the beginning: How does Congress aggressively pursue reform that extends the life of Medicare without repeating some of the mistakes of the past?

Mr. Blum?

Mr. Blum. So, a couple points.

I mean, one, I think Congress should recognize that there was many changes made to the Affordable Care Act to reduce spending on post-acute-care savings. Of the Medicare savings that were included in the

Affordable Care Act, home health, skilled nursing, all the different payment systems did experience payment reductions.

I believe that over the long term what we need to do is to shift the system, as Mark suggested, to ensure more accountable total care models. And I think what Congress can do is to provide clear direction, clear roadmaps for how that system should change over time.

The President's budget set a goal or a target for post-acute-care bundling by 2017. Really, our intent there is to send a clear signal, give a direction of how the health delivery system should move.

We also feel in the interim that we have to take other payment steps in the short term to ensure that our payments are more accurate relative to the cost of the care. The President's budget has several ideas how to achieve that.

But I think the most important thing long term is to ensure that we can achieve more of a site-neutral payment or realign the incentives of post-acute-care providers --

Chairman Brady. Got it. All right.

Mr. Miller?

Mr. Miller. The things I would say is you want to probably move in steps. So when you are taking rates down, because they are overstated, you move in a series of steps over time.

As I said in my opening comments, you try and also get the underlying payment system to follow the payments to the complex patients so that you are not taxing the facilities that are going after the most difficult payments.

And then I agree with the comment over here that if you can get to payment systems that are more population- or episode-based, you give the provider flexibility and allow them to move the resources around, as long as you have protected the risk to the program.

Chairman Brady. Mr. Miller, you referenced MedPAC's work on neutral payments in your original testimony. We have a real interest in that area.

Why have you focused on that policy area? How important is it that we pursue that?

Mr. Miller. I think the Commission believes it is very important. This has been a problem that has been around for 15, 20, 30 years. When I started, people talked about it, and it is still -- I think the fundamental problem is twofold.

One is, at the seams of these payment systems, you create odd incentives. So if one payment system pays more than another for the same service or the same patient, then people begin to behave in ways that are not clinically driven and, instead, driven to maximize payments. And you get behaviors that affect the beneficiaries out of pocket and behaviors that affect the program expenditures, but you also stimulate changes in the environment.

We think that some -- ambulatory care -- one second, off-point -- we think that that payment has stimulated purchase of physician practices, for example.

One quick, well, you know, wrap up, the Commission has talked about site-neutral payments in the ambulatory setting, with more of that coming out in our report today. Here, we are looking at the

site-neutral payment between hospitals and long-term-care hospitals and just beginning to think about some of the relationship between the in-patient rehab facility and skilled nursing facilities.

Chairman Brady. Tell us about the unified assessment tool that you referenced in your testimony, how does that work? How far along is it? What kind of insight does it provide us as we are looking at reimbursement issues?

Mr. Miller. And I may throw this over to Jon because he will probably know more about what the current state of play is.

But the fundamental situation is, and particularly in post-acute care, the two things you are generally looking for is the diagnosis and condition of the patient, but beyond that what you want is their functional status -- their ability to walk, their ability to do things like that.

What we have are these instruments in different settings that measure that different ways. And, in some settings, they don't have a consistent instrument. And that means you can't compare the patients across settings and figure out whether the payments and the outcomes are calibrated.

There was a demonstration done by CMS. And we had called for this a long time back, that an instrument needed to be created. And CMS developed one and did a demonstration. And my view of it is that demonstration is pretty promising in saying that you can measure patients consistently across a lot of these categories.

Its status, et cetera, I would hand off.

Chairman Brady. What is the status, Mr. Blum?

Mr. Blum. The status is that we have spent the past several years demonstrating, working with providers, the CARE tool. We feel confident that the CARE tool shows promise in how we push it out to all our different payment systems. Through our Center for Innovation Projects, we intend to use the CARE tool, to some degree, to assess how patients fare once you integrate the payments.

So we are at a point where we feel confident within the CARE tool that it still needs refinement, but we believe that it holds tremendous promise, as Mark said, to assess patients across different care settings. And CMS plans to deploy it for the first time through our payment innovation --

Chairman Brady. Would you, by letter, share with us how the tool works and methodologies --

Mr. Blum. Absolutely.

Chairman Brady. -- for arriving at it and the status of it? That would be very helpful.

Mr. Blum. Absolutely.

Chairman Brady. One of my concerns, that you referenced earlier on, is that we don't have criteria in the SNFs and rehab hospitals, and we are getting to bundling payments. But my impression has been that CMS has had the requirement and direction from Congress for many years to develop these criterias and to move toward bundled payments. I guess my overall question is, why is it taking so long?

Mr. Blum. Well, I think, to me, there are several challenges.

Number one is that post-acute-care marketplace has been established over time very differently across the country. Different parts of the country have a different mix of services. So defining one unifying definition to what an episode is is challenging, given the current marketplace.

The other challenge, is who gets the money? Does the hospital get the money and then decide where the patient goes and then pays the provider, versus having a locus of payment being more with the post-acute-care provider system.

Those are very important questions that we are testing. Through our current work on bundled payments, we are, for the first time I think, really establishing common payment episodes, testing four different models. And there really is no off-the-shelf model that we know of that CMS can simply put to our payment systems.

We are working very collaboratively with the hospital industry, post-acute-care industry, to define those episodes. And I think for the first time, the agency is building the infrastructure, not for just micro-tests but for large-scale transformation, to move to a more integrated post-acute-care system.

So it is challenging, to be sure, but we feel confident that for the first time the industry, the healthcare delivery system, is building the platform to develop a very extensive bundled payment system.

Chairman Brady. Thank you, Mr. Blum.

Before I recognize Mr. McDermott, at some point, Mr. Miller, during the hearing I hope you will address the President's budget's focus on market basket updates. MedPAC has included rebasing as part of your recommendations, as well. At some point, I would like to hear why.

Mr. McDermott is recognized.

Mr. Miller. If you don't get to that, make sure that you come back to me.

Chairman Brady. Okay.

Mr. McDermott. Thank you, Mr. Chairman.

One of the issues -- we have made reforms since 1997. It was called the Affordable Care Act. And that has made real changes in what is going on, I think. And we shouldn't ignore the law of the land, as the Supreme Court has now described it.

One of the questions that Mr. Brady raises and I would like to follow a little bit is, if you look at the numbers, it is Florida, it is Texas, it is Mississippi, it is Louisiana, it is Oklahoma, where there is higher home health use and aberrant -- they are outliers in the system.

Explain to me from a clinical point of view why that is. Why do you have that part of the country that has this outlying status, while all the rest of us are kind of clustered in the middle?

Mr. Blum. I think there are many reasons for the extensive variation that we see in healthcare spending. And I think you really have to break it down by different payment systems and different spending categories. There is no one uniform rule --

Mr. McDermott. I think it is 25 counties in those 5 States are the furthest out. It is very clustered. So is it just who is practicing in those counties? Is that what is going on?

Mr. Blum. I believe, and based upon our work with law enforcement, there is tremendous fraud going on in certain parts of the country, particularly with home health areas. That has been an extensive focus for our work, to reform payments, to do more HEAT Task Force, working very closely with our partners in law enforcement.

To respond to the variation, that a payment solution or an integrated payment bundle is not going to be the only solution that I believe that we need to consider. For different areas of the country, for different sectors, there are different responses. Some might be law enforcement responses, some might be better coverage policies, some might be payment reforms, but there are different reasons that drive different spending variations.

And I think the home health example that you cite, particularly in some parts of the country, are not due to payment incentives but due to fraudulent behavior.

Mr. McDermott. I remember when we had this debate in 1997. The State of Washington had an average of 17 home health visits per year, or per patient, and Louisiana had a 125 or 140 or something. And it was very hard to see what the difference was, I mean, why that was going on.

So you are telling me that same thing is going on now, 15 years later, and we haven't figured out a way to get to it. Is that a fair estimate of where we are?

Mr. Blum. I think that it is clear to us that the higher uses of home health services, particularly in the areas of the country that you cite, are not correlated with better quality of care or lower hospital readmissions. The parts of the country that we see that have really managed readmissions well use relatively few home health services compared to the areas that you cite.

So the long-term strategy really is to build the global payment incentive, but the short-term strategy is to respond through fraud and abuse controls, payment reductions, to ensure that we both control the integrity of the payment system against the long-term vision.

Mr. McDermott. Let me ask you about the -- now, Mr. Brady has asked about the issue of an instrument to measure who should go where. And we have this rule, this 3-day rule. And I have never understood what the clinical basis for the 3-day rule was. Is there such a clinical basis?

Mr. Blum. Well, my understanding is that the 3-day rule is set by statute. It was set a long time ago. And I believe that the rationale when Congress established the 3-day rule was to ensure that patients who are discharged to a skilled nursing facility have a high clinical demonstrated need for therapy services.

Mr. McDermott. And that requires 3 days in the hospital to establish that; is that correct?

Mr. Blum. Correct.

Now, that is a statutory requirement. And we are very interested in testing models that give more flexibility to the 3-day stay. But our belief is that those should be tested in contexts where we have global payment accountability, to ensure that we don't overuse services.

But, you know, within those contexts, like ACOs, for example, we are very interested to test more flexibility for the 3-day stay, to give more clinical discretion to discharge direct, for example, to the skilled nursing facility. But it has to be with a common assessment tool, to our belief, and also in a global payment arrangement.

Mr. McDermott. Now, tell me the difference, if two patients are standing here before us, and one of them is going to go to a nursing home because they -- or they need skilled nursing care -- they both need skilled

nursing care. One of them goes into the hospital and gets admitted, and one of them goes into the hospital and goes into observational status.

What is the difference? And who pays for what? Would you please explain that for me?

Mr. Blum. Sure. Well, I think we are definitely seeing a growing trend in outpatient observational services.

Mr. McDermott. You have a huge spike.

Mr. Blum. Huge spike. And there are different reasons for that. And I think some hospitals argue that it is because of the RAC, recovery audit reviews, to ensure they get it right the first time. Some argue that a patient walks into the ER, has no place to go, doesn't merit an in-patient stay, but the physician doesn't feel comfortable sending that patient home.

But it is clear to our rules that to qualify for the 3-day stay, the observation services do not count, that the in-patient stay does count.

Chairman Brady. Thank you.

Mr. Johnson is recognized.

Mr. Johnson. Thank you, Mr. Chairman.

Mr. Miller, MedPAC is focused on both reducing market basket updates and rebasing for home health and skilled nursing. Can you articulate why MedPAC has focused on rebasing in addition to market basket reductions and the Obama administration has only focused on market basket reductions?

Mr. Miller. Okay. There are a couple of sets of arguments.

So, on the skilled nursing side, as I said, there has been a decade of very high profits. There does not appear to be a relationship between profitability and patient characteristics. What drives cost does not seem to be very clear.

And when we look at the data, we can organize the data into efficient providers, providers that have low cost and high quality, and they can make higher profits at lower payment rates. We also noticed that, in managed care, many managed care plans don't pay at these rates for skilled nursing facilities. So our argument is, don't continue to inflate a rate that is already too high; stop inflating and reduce the rate. And that is what we call rebasing.

But our concern, and this is what I tried to say in my opening 5 minutes -- and I am trying to answer your question, Mr. Chairman, as well -- our concern is, let's make sure that if there are certain skilled nursing facilities that are focused on the most complex patients, that we are also changing the underlying payment system so that the dollars move to those kinds of providers, so when the rate is reduced, that you don't harm the facilities taking the complex patients.

Now, just let me -- one other thing. On home health, the story is a little bit different. In home health, when the base rate was created, there were about 30 visits provided over 60 days, and the base rate was based on 60 days. Over time, home health agencies now provide about 22, 20-some-odd visits per 60 days. They are tilted a little bit more to more skilled visits, but it was based on many more visits.

And, again, here is a situation where the profit margins for the home health agencies have been very high for a decade. And so, once again, we have suggested that the rate should come down. And, just like I told

you on the skilled nursing facility side, alter the underlying payment system so you don't harm the home health agencies that take the complex patients.

I am sorry that was so long.

Mr. Johnson. That is all right.

Nearly a decade ago, when CMS implemented the modified 75 percent rule, it did so partly based on the high number of relatively simple joint replacement cases being treated instead of less intensive settings.

Isn't it true that the number of these types of patients treated in IRFs has declined substantially? And isn't it the case that IRFs are treating more medically complex patients than they were 6 or 8 years ago?

Mr. Miller. It is true, those types of patients have moved to skilled nursing facility and home health settings in the data that we see. In-patient rehab facilities are treating a different mix of patients over time as a result of -- I think it is actually the 60 percent rule. That used to be the 75 percent rule.

Mr. Johnson. So we cut their reimbursement because they are treating more complex cases?

Mr. Miller. I think, actually, their margins are still in the 7, 8 percent range, if I am not mistaken. I think that what went on there is there were strong incentives given to have a different mix of patients as opposed to a rate reduction.

Mr. Johnson. What can Congress do to make sure that patients are getting the right care in the right setting?

Mr. Miller. I think what both of us have been saying is, you know, like your 3-day rule question and the 75 percent rule, or 60 percent rule, whichever it is at the moment, these are all things that, you know, we as Congress and Jon as CMS have to put in place because you have this fee-for-service system and you are sort of chasing these payment systems around, which are all siloed.

I think Jon was saying and I think the Commission would agree, if you could get to a more bundled payment, either on an episode basis or a population basis, you could step back from these rules, have the provider decide what the actual mix of services is, as long as the government's risk has been -- and the beneficiary's out-of-pocket risk has been managed for the episode or for the population.

Mr. Johnson. Thank you for your response.

Mr. Chairman, I yield back.

Chairman Brady. Thank you, Mr. Johnson.

Mr. Kind?

Mr. Kind. Thank you, Mr. Chairman.

I want to thank our witnesses for your testimony.

I think this is an important hearing. I think there is tremendous opportunity to enhance the quality of care in the post-acute-care setting, at a substantial cost savings as well. But it is frustrating, because this is really a subset of a larger issue that we are trying to get at, overall healthcare reform. I think MedPAC has done a good report, and CMS has been dialed in on the utilization variation that exists throughout the country and certain outliers, as Dr. McDermott just pointed out.

My question is whether or not we can address that issue with a scalpel as opposed to a hatchet, as opposed to just rate reduction, so that we are not penalizing those areas that aren't overutilized and still producing great results, and whether or not we have the wisdom to distinguish between the two.

I mean, I reviewed again last night MedPAC's report of March of this year, page 199. And you highlighted Wisconsin being way below the national average on episodic care and yet producing great results. And the fact that 25 counties with the highest utilization had an average utilization of 88 episodes per 100 beneficiaries.

If the policies to reduce fraud could lower utilization just 18.5 episodes in those areas, it would have declined by 290,000 episodes, or about 80 percent, at a cost savings of close to \$800 million in 2011 alone.

You indicated, Mr. Blum, that there may be some fraud involved with that, but there is also, I would assume, a high concentration of providers in those areas, too, which is driving a lot of the utilization patterns, as well.

Is that part of what is going on in these outlier areas, is the intense concentration, and therefore you are going to get a lot more episodes of care and prices being driven that way?

Mr. Blum. I think it is clear in our data, and I think this is also mirrored in data by MedPAC, the IOM, that there are certain parts of the country that use a distinctively different mix of services, particularly for post-acute-care services, and seem to have the same outcomes, if not higher outcomes. And our data that we see for a given DRG episode of care, that total cost over a 30-day episode can vary from a factor of two to one, sometimes even more.

And it is really the post-acute-care services, not what happens to the patient in the hospital per our payment rates, but what happens after that patient leaves the hospital. Is there a high probability for readmission?

There are parts of the country that demonstrate that the program can do a lot better overall to reduce hospital readmissions, better manage care transitions. But if you run the correlation between post-acute-care spending, even controlling for the patient risk, there is no correlation for the quality of the care that the patient receives that we can see.

So I think there is tremendous opportunity to change the payment system over time. It will take a transition. But what is clear is that certain parts of the country use relatively few post-acute-care services and seem to have better outcomes, measured by readmissions, for example.

Mr. Kind. Well, it seems like we need better data, too. And it sounds like the Center on Innovation has been dialed in on this.

Are there any comparative effectiveness research studies going right now in post-acute-care settings to get us better evidence-based practices and protocols out there?

Mr. Blum. I mean, I think, to our analysis, there is some very good work that says when you really target those services really well -- a home health visit for the patient that has just been discharged -- that there are better outcome. We need to figure out what can be scalable, and that is the work that the Innovation Center is doing.

But it is clear that some parts of the country really have figured this out well, and we need to understand that and then disseminate it through more parts of the country.

Mr. Kind. I think the key is trying to figure out what the proper setting is, what the proper treatment is, to get better results at a better price.

Mr. Blum. Absolutely.

Mr. Kind. I mean, that is really the name of the game here.

You have just mentioned the four bundled payment models that you are moving forward on right now. But it is my understanding that, even under the bundled payment being tested, it typically retains the existing fee-for-service payment rates with kind of a virtual bundle above that.

Isn't that kind of counterintuitive to where we need to go?

Mr. Blum. Well, I think we are testing different models. And I think we are also testing how fast we can establish these models.

And similar to the accountable care organization model, a very quick way for us to move forward, given our current infrastructures, payment systems, and just the marketplace realities, is to continue to pay on a fee-for-service basis but then do kind of post-episode, post-year-end reconciliations to determine savings and quality of care.

But the tradeoff really is speed versus --

Mr. Kind. Do you know, of the \$15 billion we have been able to recapture under the ACA on Medicare fraud, how much of that came from the PACS, post-acute-care setting?

Mr. Blum. I don't have that number offhand. But what I can tell you, Congressman, is that a lot of the fraud that we see in the program really comes from those providers that are very mobile: home health, durable medical supplies. And, really, that is, you know -- we see less fraud in permanent institutions.

Mr. Kind. Okay. Thank you.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Roskam?

Mr. Roskam. Thank you, Mr. Chairman.

Mr. Miller, a couple minutes ago, you mentioned that we shouldn't be taxing those providers going after the medically complex patients. Isn't that sort of implicitly what is happening with the 75 percent rule? In other words, there is this burden that is being placed upon these institutions; it is a limitation upon them.

Shouldn't we move away from the 75 percent rule, you know what I mean, and just make sure that it is something that is not revisited?

Mr. Miller. I want to deal with two things, because the end of your comment I agreed with, but I wanted to do the set-up at the beginning.

I think the intent of the 75 percent rule is that the in-patient rehab facilities were taking patients that didn't need to be there, that could have been treated elsewhere. And so I think the intent of the rule, clunky and, you know, regulatory as it was, was to do that.

Now, to the second part of your question, I think, which is, yes, I think that objective is to get away from rules like that. And, again, I think you are hearing a fairly consistent message, which is, set the payment, allow the provider to manage within that patient, and if it is a couple of days in the IRF and then 2 weeks of home health versus a different patient has a different mix, fine. But the payment has been tied to what the patient needs, and then the exact mix the provider will execute.

Mr. Roskam. What I am hearing from a Tier 1 rehab facility in my district is sort of the -- really the heartache of stories of, look, we can't care for this person, who desperately needs our help, based on our census. And so I am sensing from you, look, let's move away from this.

Mr. Miller. Move away from that, but also remember those rules. It is not that each and every patient has to meet that criteria; 60 percent of the patients have to meet that criteria.

So there is some flexibility to pick up a patient that you say, well, they might be on the other side of the line, but I am going to take them because of their need because my overall census, to use your word, falls within the rule.

But, again, that is clunky and not the ideal place to be.

Mr. Roskam. And even the 60 percent, that is not driven by any data, is it? I mean --

Mr. Miller. Well --

Mr. Roskam. -- what is the argument for 59? What is the argument against 58?

Mr. Miller. Oh, the actual percentage. My understanding of how the rules got set up is that clinicians came together and sort of looked at what types of patients needed to be in these types of facilities and struck a rule. Whether it is 60 percent or 75 percent, I don't think there is a lot of science in that.

Mr. Roskam. Right. And the other thing is, the clinicians were induced based on what? Either we are going to make a rule or you are going to make the rule, so come up with the rule?

Mr. Miller. Hit me one more time?

Mr. Roskam. In other words, there is one thing to say, let's come up with some sort of artful way. There is another thing to say, there is going to be a rule that is going to be imposed, come up with the percentage. Do you follow me? How they are prompted and the environment in which a rule is created.

So I am not necessarily satisfied that even this 60 percent rule is something that they would come up with on their own. They were told, look, there is going to be a number, on the bus or under the bus. You write the number, or we are going to write the number.

Mr. Miller. And I will say this. And I understand your thinking here, and it is thinking that was very consistent with my own. But, for example, I don't know how many years ago now, I am going to say 7 or 8 years ago, the Commission has been pushing on the need for criteria for long-term-care hospitals. I have many times sat with the industry and said, where are the criteria? And it has been pulling teeth.

And the criteria, bluntly, that have come forward are, in many instances, very self-serving. They basically codify exactly what is out there.

Mr. Roskam. Right. I have heard some of that. I get that vibe.

Mr. Blum, just quickly, CMS is proposing to pay rehab hospitals a nursing home rate based on certain types of conditions. What animates your hope that that is ready for prime time? And if you are proposing to do that as a cost-saving measure, what are you proposing to reduce in terms of regulations to allow them to administer that service at that price?

Mr. Blum. Well, I think, as Mark and others have said, there are clear areas where we can see overlap, where patients with similar needs, similar clinical characteristics, are treated in different silos of payment that we currently operate. And I think what we are trying to get to is payment that is neutral.

And what I believe the President's budget says, for a very small step, to neutralize the payment, given the payment differences, for conditions that we see a lot of overlap. This, to me, as small step until we get to a more permanent, longer-term payment policy.

I think it is a fair question for Congress to ask; well, how do we assess that the patients are kind of treated similarly? I think one area for consideration is that, if this change were authorized, to direct us to use the CARE tool as a step to ensure that we do see consistent outcomes.

But I personally would frame this policy as one small step towards site-neutral payments, but one that we are comfortable proposing.

Chairman Brady. Thank you.

Mr. Pascrell?

Mr. Pascrell. Thank you, Mr. Chairman.

And thank you to the witnesses. You have been clear, succinct.

I am astounded, Administrator Blum, as to how candid you have been, not just today, about fraud in the system. And I wasn't going to talk about this, but the amount of money, when we know that health care is part of the entire economy, and it is growing, that we are losing every day because of these mobile, for instance, providers.

Do we know who they are?

Mr. Blum. I think we are much better able today than previously to spot fraud before it happens. And one of the things that we have built at CMS that was mandated by the Congress was what we called the fraud prevention system, where we now, before claims are paid, we can spot patterns, we can see things, we can refer them to further investigation.

But I think, to us, the key is to use claims systems much more smartly, more wisely, so we can spot behavior that is problematic. Because we know that behavior that is fraudulent isn't isolated, that it moves; once we bring in law enforcement resources, that it tends to move.

So we have to be smarter, we have to get away from pay-and-chase, and much more about predictive data --

Mr. Pascrell. Most of the fraud is still on the side of the providers, not the folks that are getting the care; isn't that correct?

Mr. Blum. I think, traditionally, we have been focused on the providers. I think there are some instances where the beneficiaries are complicit, whether they know it or not, that their IDs got stolen. But I think, to

us, we have to move away from the past pay-and-chase system and move toward a smarter, wiser system to stop payments before they happen.

Mr. Pascrell. One of the elements of the Affordable Care Act -- I had a personal interest in it, a professional interest in it -- is the Innovation Center. I think it is very, very, very critical in terms of moving forward, as you have used the term before, both of you.

I am very excited about the promising payment and delivery reform models that can transform both Medicare and Medicaid, as CMMI takes time to test and evaluate these models.

While I understand that the Innovation Center is an important avenue for us to collaborate with healthcare providers and partners in the private sector to improve how our healthcare system works, I strongly advocated for the continuing care hospital pilot in ACA, and Congress ultimately authorized the pilot with the goals.

Now, can you tell me what the status specifically is of the implementation of the continuing care hospital model?

Mr. Blum. We are happy to provide you with a more complete response through writing. But my understanding is that our bundled payment models, the four models that I talked about, permit the same kinds of care model that I think the legislation calls for. So we believe that the spirit, the goals of the continuing care hospital model are being established through our bundled payment systems.

We are working with a wide range -- I think it surprised us, the interest -- of hospitals' post-acute-care providers. We plan to test more models over time. We have four that we have now established. I think the goal is --

Mr. Pascrell. But we haven't implemented them, correct?

Mr. Blum. They are in the process of being implemented, and our target is to have them up and running by October 1st.

Mr. Pascrell. And the Congress directed CMS to test the model. CMS does not have the discretion on this matter, as I understand it. To be clear, Section 3023 mandates that the Secretary implement the CCH pilot as well as the national bundling pilot.

Can you tell me when we expect CMS to begin pilot testing the CCH model?

Mr. Blum. I think what I can say to you today is that there are four models. To me, they include the spirit of that language. And I will be happy to get back to you with a more precise answer.

RPTS BLAZEJEWSKI
DCMN HOFSTAD
[10:25 a.m.]

Mr. Pascrell. Thank you very much.

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

Chairman Brady. Thank you.

Dr. Price?

Mr. Price. Thank you, Mr. Chairman. And I want to thank you as well for holding this hearing.

And I want to thank our witnesses.

I always like to try to talk about patients, and just as a little, maybe a non sequitur, but there is an urgent issue, Mr. Blum, as you well know, with the whole issue of DME and going to phase two and round two of the competitive bidding model, that many of us believe -- in fact, a letter was sent to Ms. Tavenner, signed by a 226 bipartisan group from Congress, to urge a delay in this, because real people in real communities across this land, we believe, are going to be harmed in very specific ways. And so I would draw your attention to that letter and urge you to take that message back to Ms. Tavenner, please.

A delay of 6 months, we believe, would be a zero cost, because the current requirement is to have it done by the end of the year, so we can move toward a positive system, market price purchasing system.

I do want to follow up on the issue of fraud, obviously, 25 counties that have the highest level of fraud. And the providers get whacked with this. There is a significant number of just fraudulent actors, not even providers, who take the government for significant amounts of money and then move on when they get identified.

Mr. Blum, do you know what that percent is?

Mr. Blum. I think it is hard for us to quantify what a precise rate of fraud is. The Congress did direct us to try and calculate that. What we do know is that there is a substantial number, too high a number, to our minds, of bad actors that bill the system.

We are moving the system from the pay-and-chase model. We are trying to find those actors. But I do agree with you that it is a small percentage but that it is one that creates vulnerabilities that we have to respond to.

Mr. Price. Most of the providers out there that are trying to care for these patients in oftentimes very, very difficult situations and decreased reimbursement that has challenged them to a significant degree are just trying as hard as they can.

Reducing market basket updates. It seems to me that modifying this payment that CMS is talking about is being done more with the budget in mind as opposed to patients in mind.

And what are your metrics that relate to being able to determine the cost of compliance with the regulations and the rules for the folks? Is that part of your equation for what you pay in a market basket?

Mr. Blum. Well, I think the main metric that we look to is margins and how are the Medicare payment rates relative to the cost of care. And what we see in all of our post-acute-care payment systems, SNF and home health and in-patient rehab, is very high margins.

Mr. Price. But what is a margin that CMS finds acceptable? How much?

Mr. Blum. We don't have a defined standard, but I think when we see margins that are in the double-digit rates, that gives us very strong concerns that our payment rates are too high relative to the cost of care.

Mr. Price. Is CMS the one defining the cost, or are the folks actually paying the bills defining the cost?

Mr. Blum. Well, we have cost report processes where we collect costs based upon the costs of care that are submitted to us by CMS. But it is really the cost of -- excuse me, to CMS. But it is really the cost of the care provided to that beneficiary.

We have to be mindful that our regulations don't -- I mean, are smart, that are wise. We have taken regulations off the books in the last couple of years to create more flexibility. But, to our analysis, when we see margins that are in the double-digit rate, that is a clear signal that the program overpays relative to --

Mr. Price. And I appreciate that. I think it is important for people to make certain that we are hearing what is being said, and that is that the Federal Government believes that there is a certain amount of a margin that is correct and a certain amount that is not. Many of us find that fairly chilling.

I want to move to the issue of the unified assessment rule and this CARE tool that is being considered. Do you know the cost of the compliance with this CARE tool that is being set up?

Mr. Blum. One thing that we do hear from providers that have tested the CARE model, that there are many questions, too many questions. And we don't have a set number of questions in mind. We are very, I think, open to refining the tool based upon --

Mr. Price. But do you know the cost -- is there a target cost to the provider that CMS is looking at for compliance with the CARE tool?

Mr. Blum. Not that I am aware of. But I think our goal is to make sure of two things: number one, that we, the Congress, MedPAC, all of us, can assess patients that are treated in different settings to assess, does it make sense for this patient to be in home health versus SNF --

Mr. Price. It is a different question, though, Mr. Blum. The providers have to comply with what you dictate. And if there is a cost to that compliance, if that is not being factored into what you are paying, then you are not paying attention to what happens out there in the real world.

Mr. Blum. What I can say is that all of our payment systems today require an assessment. SNF has their own system. Home health has their own system. IRF has their own system. So that is, to my analysis, already built into the system.

Our goal is to simplify. Many post-acute-care providers both own SNF, home health, and long-term-care facilities, for example. So, hopefully, one common assessment should reduce provider burden, particularly those that have multiple care settings.

Mr. Price. Thanks, Mr. Chairman. I look forward to following up.

Chairman Brady. Thank you. Thank you, sir.

Mr. Buchanan?

Mr. Buchanan. Thank you for holding this important hearing.

And I also want to thank our witnesses for taking their time today.

Mr. Blum, with regards to in-patient hospitals that provide rehab, I want to go back to the 60 percent rule. How do we know, from your standpoint, that it is not working? I guess that is the first thing.

And the second thing, I am just concerned about a lot of patients. I am from Florida. It is a big issue in our area. I am very concerned about patients having access to quality care and that a lot of them might be exempt as a result of going from 60 to 75 or whatever that number might be. So I would ask you that question.

Mr. Blum. I think our starting principle for post-acute-care payment systems is that we recognize that each of our payment silos has a distinct need and a distinct focus in the care delivery system. And so we feel that all of them are important and that serve beneficiaries well.

We also know there is overlap. And given, as Mark described, differences in cost of care -- quite significant between those patients, for example, who are treated in a skilled nursing facility and those in an in-patient rehab facility -- that while we develop this longer-term strategy, that we need to do more to ensure that patients get treated in the right care setting, given the payment differentials.

Mr. Buchanan. But you are confident that people will have the same quality of care in terms of access to facilities by raising that bar?

Mr. Blum. Well, I think we know there is overlap, we know that quality varies across the country. As during the previous question, the question was, how did the agency come to the 60 percent? That was done with the collaboration of clinical input. And I would say that if the Congress chooses to authorize this policy to change the 60 percent to the 75 percent, one thing the Congress might want to consider is to make sure that change does have clinical validation and input.

But we do think it is appropriate for us to take some more incremental steps to make sure patients are treated at the right place at the right time while we develop more of the longer-term strategies.

Mr. Buchanan. And, Mr. Miller, in your written testimony, you conclude that post-acute-care spending has doubled since 2000. What are the biggest contributors to that, based on your statement?

Mr. Miller. I think, you know, at a conceptual level, I think probably the biggest contributor is how difficult it is to define the need for the service. And so it is very hard to decide when to start and when to stop.

If you want to get more mechanical about what is going on, the underlying trends, there has been in some of the post-acute-care providers a large influx of providers, and I think that that is, in part, because some of the rates are so attractive, that people come in. You have more users of the service and more services per user. So if you think about the growth-driving factors, that is what has been happening in a lot of the environments.

But I think the fundamental concern is the payment rates have been set very high in some of these settings and providers have come in.

Mr. Buchanan. Mr. Blum, real quick, I want to echo a little bit what Dr. Price mentioned about competitive bidding. I can tell you that it is a big issue. I have talked to a lot of people across the State of Florida. But I have one person in my district, they are looking at a 40 percent cut on one product that they sell. Talking about 500 employees; probably going to have to lay off half of them.

This is a big issue all over Florida. I know that Dr. Price mentioned there are 227 Members on a bipartisan basis. Someone like myself that has been in business 30 years, the whole concept of competitive bidding or bidding, you have to make sure these are legitimate bids, and "legitimate" meaning people can deliver based on what they are talking about under these contracts.

But there are a lot of people that are going to be negatively affected with this bidding process if this isn't done in the proper way. And I know locally we are talking about a lot of jobs, not just in my district but across Florida, because of this process.

And I hope that you guys -- and I just don't know how you cut someone 40 percent. That is not staged in a whole industry, and this is just one industry. So I would just like to have you respond quickly to that.

Mr. Blum. We understand that the competitive bidding model is a transition and one that is complex and one that is a significant change from the current way that the Medicare program pays for durable medical supplies.

I would say there are three things why we think this program is so vitally important. Number one, the program currently overpays relative to what we know private payers pay. The program will save substantially relative to the current payment rates.

Number two, I think, going back to the fraud issue that was raised previously, by working with a better-screened set of suppliers, we are confident that we can reduce the error, the fraud that historically we have seen in the program.

And I think, number three, what I would say is, we have tested this program in nine parts of the country. And the arguments that we are hearing today we heard before we started the nine areas of the country: Beneficiaries would go without supplies, there would be waits for supplies. That hasn't happened. And we have tracked this program more carefully than the Medicare program has tracked ever before. We have not seen the disruption that the industry argued would happen back in 2011. That gives us great confidence we can move forward.

We will pledge to work with this committee, with the Congress to be share the same data we look at, 100 percent claims analysis, to ensure that our beneficiaries have the supplies they need and have the best possible care delivery.

Mr. Buchanan. Thank you, Mr. Chairman.

Chairman Brady. Mr. Smith?

Mr. Smith. Thank you, Mr. Chairman.

And thank you to our witnesses here today for sharing your insight and your recommendations.

As well, I am concerned about the sustainability of Medicare and want to look at not only the short-term but the long-term solutions so that we can see Medicare in a more sustainable fashion.

We know that there is a large difference in terms of delivery to urban areas compared to rural areas. Obviously, I represent a very rural constituency. And I want to ensure the changes we make to Medicare do not further limit access to critical services to people living in rural areas.

Mr. Miller, when MedPAC was looking at ways to reform payments to post-acute-care services, did you research whether these reforms would impact access to our rural communities? And if so, how?

Mr. Miller. We did.

And we recently, I think it was in June 2012, did a fairly extensive report on rural services, access, quality, that type of thing. And when you look at service use, whether we are talking about physicians, hospitals, skilled nursing facilities, home health, ESRD drugs -- we looked at a range of different things -- the utilization rates between urban and rural areas are not all that different.

The only real place that we found a difference is, in the most frontier counties of the country, there is a lower home health utilization rate. But everything else, pretty consistent.

Mr. Smith. Can you elaborate on "most frontier counties"?

Mr. Miller. I may get this wrong. I think it is six persons per square mile, something like that.

Mr. Smith. Okay.

Mr. Miller. And I may have that all wrong. I can tell you, just not this second.

Mr. Smith. Okay. Thank you.

Mr. Miller. The thing to keep in mind that I want to get across to you and the committee, it is not about urban and rural. If you go to Louisiana, the highest utilization rates in the country in Louisiana, Texas, areas like that, it is urban and rural. If you go to South Dakota, you have low utilization urban and rural. It is much more a phenomenon of practice pattern and sort of entrepreneurial service utilization than it is an urban and rural phenomenon.

And I just want to get this last thing in here. I am sorry, I know you want to go again. But, you know, our view is, if you find a problem and you think that there is an access issue, target the solution to that, as opposed to saying, okay, here is a payment for anybody with "rural" in their name and then, you know -- for example, in home health agencies, the rural margin is actually higher than urban. So our point is really about targeting it to access problems.

Sorry.

Mr. Smith. Okay. Thank you.

Mr. Blum, in your opinion, would any of these proposals be detrimental to providers in rural communities?

Mr. Blum. I think we always have to be mindful of that and to make sure that beneficiaries throughout the country have access to quality services.

As Mark said, home health, for example, that we see high margins consistently throughout the entire industry, for-profit, not-for-profit. So that gives us confidence that we can lower payments without compromising quality of care.

But I think it is a fair demand that Congress should put on the agency to monitor what happens to beneficiaries realtime with these payment changes. I talked about the work that we have done on dialysis care, for example.

So I think, if Congress were to adopt these policies, one recommendation that I would have is for Congress to demand CMS to monitor what happens realtime to make sure the quality of care throughout the country is not compromised.

Mr. Smith. Okay. Thank you.

I yield back.

Chairman Brady. Thank you.

Mr. Gerlach?

Mr. Gerlach. Thank you, Mr. Chairman.

Gentlemen, let me go back to this 60 percent rule issue just so I can get some clarity in my mind over it.

As I understand it, the in-patient rehabilitation facilities receive their reimbursements based upon a prospective payment system. Is that correct? That was transitioned into being somewhere around 2000? Is that right?

Mr. Blum. [Nonverbal response.]

Mr. Gerlach. Okay. So if that prospective payment system is properly structured, in terms of identifying the types of services that would be necessary for a patient with a certain diagnosis, and the bundling of the care that goes into that payment mix is appropriate, why is there a percentage rule at all as to how many patients overall that facility has that might be Medicare-eligible for certain services versus a patient that comes in needing rehab for a broken leg because of a motorcycle accident who is 23 years old? Why is there any percentage rule applied in any way, as long as the PPS payment system is appropriately structured?

Mr. Miller. I am sure Jon has things to say here, too, so I will try to keep it short.

The issue that you always get with a prospective payment system is, if you set up a payment, what a provider may do -- and I am not saying all of them do it -- may try and figure out how do you maximize payment with minimum amount of effort. And so you have a set of categories, you classify a patient, you assign a dollar, but if I can figure out how to get a lower-severity patient in there, I can increase my revenue.

And this isn't just in-patient rehab facilities. You see this throughout the post-acute-care setting. I mentioned earlier, home health was built on the assumption of 30 visits. They are now delivering 22, on average.

So, in a sense, and this is what is clunky and unhappy about these silos and fee-for-service, is you will observe patterns and then you will put in criteria trying to reorient the incentive structure for the provider.

Mr. Gerlach. But, on that point, if I can -- and, Mr. Blum, I would like your comment, too. On that point, you are saying that the provider is trying to, based on that payment structure, determine what the nature of the patient is coming in to get the service and trying to get a less-severe patient, from a healthcare conditions situation, into the facility, knowing you are going to get a better reimbursement out of that, versus taking on a more --

Mr. Miller. Complicated.

Mr. Gerlach. -- complicated situation.

Mr. Miller. Uh-huh.

Mr. Gerlach. But the point still stands. As long as whatever the service is being provided meets the criteria, what difference does it make overall to the total patient mix? Whoever the patient is that comes into that facility needs a certain amount of care for a certain condition.

Mr. Blum. I would agree with you.

Mr. Gerlach. And if the bundling payment is a fair payment for the service provided, why is that an issue for you as to, what, it is 60 percent, 75?

Mr. Miller. It is whether it is fair based on who is coming in at that point in time versus when it was fair when it was set up. So you may have set it up and said this is the mix of patients and here is the payment, and then you find yourself 5 years down the road and there is a different mix of patients in there but the payment has continued to reflect the higher complexity. That is the problem.

Mr. Gerlach. Mr. Blum?

Mr. Blum. I would agree with what Dr. Miller just said, is I think that if we have payments that were neutral to the patient's conditions, that it shouldn't matter which setting that they would be served in. But because we have such differentials in payments between skilled nursing facility payments versus in-patient rehab versus hospital, in order to protect the trust funds and also to ensure patients get served in the best setting, we have to think about these criteria, like the 75 percent rule, to make sure that the right patient gets treated at the same time.

The rules also say that, for an in-patient patient, they have to withstand very intensive therapy, they have to withstand, you know, very intensive services. So we have to have determinations of who goes to the right place at the right time, both to make sure that the care is appropriate, but, given the payment differentials, that the trust funds are protected.

We believe over the long term we need to move away from these more crude and clunky measures like 3-day stay, 75 percent rule. If we can figure out what the right mix of site-neutral payment is long term -- we don't have that definition, and no one does that I am aware of right now -- that we can phase out some of these more clunky definitions.

But until we can figure this out longer term, then I believe we need to have these definitions, but can test ways to relax them, so long as we have total cost accountability built into the system.

Mr. Gerlach. Okay.

And real quickly on home health care, if I can -- and I would like to have both your comments.

I had a constituent that went in for 3 days of home -- or had 3 days of home healthcare services. He was billed \$1,500 for the services and turned that over to CMS. And the CMS folks reimbursed the home healthcare agency \$3,000 for those 3 days of care -- in essence, reimbursed the agency double what they billed for the service. And the explanation we got from CMS was that, well, over the course of a 30-day episode of care, a pro-rational reimbursement amount was \$3,000.

Why are you paying double what is billed in this system? Why don't you have it in your regulations, it is that 30-day episode of care that determines the amount or what is billed, whatever is less?

Mr. Blum. I think that is a helpful suggestion. I would have to become more familiar with this case. We do have short-stay outlier mechanisms in our home health payment system. But, as Mark said, the current home health payment system is based upon a visit assumption that is no longer valid.

CMS is working, consistent with the Affordable Care Act, to rebase the home health payment system. So I hope that our future payment system won't have the effect that you just described.

Mr. Gerlach. Thank you.

Chairman Brady. Thank you.

Mr. McDermott, for a brief follow-up.

Mr. McDermott. Mr. Smith asked a question, and I want to just follow up a second.

On the home healthcare issue, the ACA gave you the ability to put a moratorium on any more organizations in an area. Have you used that anywhere in the United States? If not, why not? I would like to hear your answer to that question.

Chairman Brady. And briefly, please.

Mr. Blum. We have not used it yet. We continue to receive recommendations from the industry associations, law enforcement, but we have not used it yet.

Mr. McDermott. So you have not used it.

Mr. Blum. Yet.

Mr. McDermott. Thank you.

Chairman Brady. I want to thank both of our witnesses and our Members here, as well, for their testimony today and the questioning. Your experience and ideas on how to reform Medicare's payment for after-hospitalization care to keep the system solvent are appreciated.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask the witnesses to respond in a timely manner.

Chairman Brady. With that, the subcommittee is adjourned.

[Whereupon, at 10:47 a.m., the subcommittee was adjourned.]

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