Hearing on the Evolution of Quality in Medicare Part A

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Hearing on the Evolution of Quality in Medicare Part A

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

The subcommittee met, pursuant to call, at 2:04 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [chairman of the subcommittee] presiding.

Chairman Tiberi. The subcommittee will come to order.

Welcome to the Ways and Means Subcommittee on Health hearing on the evolution of quality in Medicare Part A.

In mid-May, you may remember our Health Subcommittee held a hearing on the implementation of the Medicare and CHIP Reauthorization Act, or MACRA, of 2015. Today's hearing follows along the same theme used in that hearing.

Once a major quality program has been operating for a few years in Medicare, we review the implementation and discuss lessons learned. During today's hearing, we will review the status of quality programs in place for Medicare Part A.

The first item on our agenda is to review the many quality and pay-for-performance programs that are in place for hospitals. In addition to reporting quality measures, hospitals are also on the hook for readmission and hospital-acquired-condition penalties as well as value-based purchasing programs. As you will hear from our witnesses today, a total of 8 percent is at risk for quality performance for hospitals.

As we apply the lessons learned from hospital quality programs, we will explore how we should legislate within the post-acute care space. As we will hear from the witnesses today, post-acute care is lagging a bit behind where hospitals currently are. We will hear about the important changes that were made in the bipartisan, bicameral IMPACT Act of 2014, and we will hear directly from stakeholders on IMPACT's implementation.

Part of IMPACT's story has already been told, as three of seven quality measures for IMPACT have already been implemented. Some of the IMPACT stories will be told over the next 2 years as CMS continues to implement the four remaining measures.

But just because the IMPACT story is ongoing does not mean Congress should idly sit by and wait. Over the next few weeks, the committee will debate and deliberate over the most effective ways to incentivize high-quality, low-cost care. Whether it is H.R. 3298, the PAC VBP bill introduced by Chairman Brady and Mr. Kind, or other ideas our members have to offer, this committee will explore these ideas further.

The last thing we will address in today's hearing is how we can look to reduce the regulatory burden for hospital and PAC providers. Our witnesses will highlight the many regulatory challenges that providers face in the Medicare program. These regulatory challenges are real, and they distract from ultimate patient care. Therefore, we need to have a serious discussion about these challenges. Such discussions will likely result in real costs to the Medicare program, but it is our goal to provide relief and pay for that relief through consensus-based quality payment reforms.

Again, we are all here for the same reasons today, as I have stated in the past: to explore ways to better improve the quality of care for our Medicare patients.

I now would like to yield to our distinguished and retiring ranking member, Mr. McDermott, for an opening statement.

Mr. McDermott. Thank you, Mr. Chairman.

I notice you mentioned my retirement. That means you are going to get rid of me, right? I am sure that isn't what you meant.

This is the kind of hearing where there isn't much disagreement about the fact that we want to have quality. I mean, we are all here for that. And promoting quality is critical to the millions of beneficiaries that receive care in hospitals and nursing homes and hospices and other settings covered under Part A. And I am hopeful we can have a constructive discussion about this.

We have made some substantive bipartisan progress recently. We need to build on our success. Last year, we came together with MACRA. That landmark reform repealed the SGR and already started the process of transforming how we try to pay physicians under Medicare.

And in the Part A space, we have begun to lay the groundwork for payment reform by passing the IMPACT Act, which will give us the data we need to improve quality in post-acute care settings. These are significant bipartisan achievements that will help us continue to move forward toward a value-based system that rewards efficient and high-quality care. It will make Medicare stronger and save billions of dollars, but improving quality is not just about reducing costs. It is also about improving outcomes in ways that have real consequences for patients.

We face a crisis that this committee rarely discusses. Every year, between 210,000 and 440,000 Americans die in the hospital setting due to preventable medical error, including

180,000 Medicare beneficiaries in 2010 alone. If that was happening in the airline industry, we would have an uproar in this Congress, but in this setting somehow it doesn't get discussed. Preventable medical errors are now the third-leading cause of death in this country.

Now, we must recognize that achieving value isn't all about cutting costs; it is also about helping patients and saving lives. Payment reforms that put patients first and incorporate sound quality improvement measures are an important part of how we can address this problem.

Unfortunately, my colleagues are not always in agreement with us on this issue. The Hospital Readmissions Reduction Program, for example, cut the number of hospital readmissions by 565,000 between 2010 and 2015. Likewise, the Hospital-Acquired Condition Reduction Program has saved Medicare $19.8 billion and, more importantly, prevented the death of some 87,000 people. Yet every Republican here today has called for the repeal of the Affordable Care Act, including these lifesaving initiatives that are already improving the quality of health care provided by the hospitals.

Now, I take the chairman's call here today as an acknowledgement we are going to stop trying to repeal it and try and make it better. That is really what we all really want to do.

Similarly, the Center for Medicare and Medicaid Innovation is testing exciting new payment models that will provide us a path to move forward in the healthcare system. The data and evidence that the Innovation Center is gathering will be critical to informing our conversation about delivery system reform. Yet the Speaker, the former chairman of the Ways and Means Committee, has proposed a Republican agenda that singles out this program for elimination. Why would you single out a program of innovation as a way forward in health care?

If we are having a serious conversation about the evolution of quality in Medicare Part A and if we are serious about addressing these issues in a bipartisan way, my colleagues on the other side need to recognize what is happening right before their eyes. We have programs that are there because of the ACA that are, in fact, doing what we want: providing better care.

Quality in Part A is already evolving, and it is thanks to the Affordable Care Act. No one can put a social insurance program together and anticipate all of what is going to happen. None of us on our side who were involved in drawing it up thought for 1 minute that we had created the Ten Commandments off the mountain, which haven't been changed since Moses brought them down off the mountain. The Affordable Care Act needs some changes, needs some things in it, and I think that is what this hearing really should be all about.

And I am glad you are having this hearing, Mr. Chairman.

Chairman Tiberi. Thank you, Mr. McDermott.

Mr. McDermott. I yield the rest of my time.

Chairman Tiberi. Thank you. I think I will just say thank you. You almost got me to engage with you, but I think I will just refer now to our chairman, the distinguished gentleman from Texas.

Thank you for being here, sir.

Chairman Brady. Well, thank you, Chairman Tiberi, for your patience, for holding this important hearing.

Thanks to all our witnesses for being here.

I am really here to underscore the importance of Chairman Tiberi's bipartisan drive toward quality in Medicare. This hearing is a remarkable opportunity to examine how existing Medicare policies are incentivizing hospitals and post-hospital providers to deliver high-quality, cost-efficient care.

This is a critically important issue for several reasons. First, it is key to our efforts to preserve Medicare for the long term. By incentivizing quality over quantity, we can improve care. We can reduce duplication and waste and bring down the costs to the program, which makes it solvent for the longer term.

Second, perhaps more importantly, Medicare payment policy can significantly impact the ability of seniors and others in Medicare to access the high-quality care they need and they deserve.

Last year, Congress passed landmark legislation, which has now become law, to reform and modernize the way Medicare pays physicians. The bill puts emphasis on quality rather than quantity, a policy shift that will make a real difference in the lives of Medicare beneficiaries.

But physician payment policies are just one piece of the puzzle. To ensure the Medicare program is truly delivering the high-quality care seniors deserve, we also need to improve the way it pays post-acute or after-hospitalization providers. And we need to take the same value-based approach, rewarding providers for how well they serve Medicare patients, not how often they serve Medicare patients.

Last July, I introduced bipartisan legislation with Congressman Kind on this committee to help accomplish this important goal. Our bill, Medicare Post-Acute Care Value-Based Purchasing Act, takes meaningful steps to strengthen Medicare for the long term and improve access to high-quality care for current and future Medicare beneficiaries.

By providing the right incentives, this legislation will bring increased competition and innovation to Medicare while lowering costs to the program. At the same time, the bill

will raise the bar for patient care nationwide. It rewards providers who set themselves apart in delivering excellent care to Medicare patients.

Today's hearing is a critical first step in advancing patient-focused solutions like this one, solutions that build on our past successes in payment reform to improve Medicare for all Medicare patients.

Again, thank you to Chairman Tiberi for his leadership in this effort. Thank you to the committee members, who take progress and quality and innovation in Medicare seriously, diving into these issues and looking for bipartisan solutions to move forward.

So, with that, I yield back to Chairman Tiberi and thank you again for your leadership.

Chairman Tiberi. Thank you, Chairman Brady.

Without objection, other members' opening statements will be made part of the record.

We are joined by four individuals today.

First, we will hear from Barbara Gage, an associate professor and health services researcher from George Washington University.

Next, Elisabeth Wynn, the senior vice president for health economics and finance at the Greater New York Hospital Association. Thanks for being here.

After Elisabeth, we will hear from Steve Guenthner, the president of Almost Family.

And, finally, we will hear from Greg Worsowicz, the president of the American Academy of Physical Medicine and Rehabilitation.

Each of you will be recognized for 5 minutes. Your full testimony will be made part of the record.

With that, Ms. Gage, you are recognized for 5 minutes. Thank you.

STATEMENT OF BARBARA GAGE, ASSOCIATE RESEARCH PROFESSOR, GEORGE WASHINGTON UNIVERSITY, CENTER FOR HEALTHCARE INNOVATION AND POLICY RESEARCH, WASHINGTON, D.C.

Ms. Gage. Thank you very much for the invitation to speak today and good afternoon, Chairman Tiberi and Ranking Member McDermott and the other esteemed members of the subcommittee. Thank you for the opportunity to testify on incentivizing quality outcomes in Medicare Part A.

As mentioned, I am a health services researcher, and I have been working in these areas for many years. I have led a lot of the Federal national studies for the Centers for

Medicare and Medicaid Services, looking at post-acute care payments and quality reform over the last 20 years, and I would like to leave you with four important points today.

One is that one in five beneficiaries are hospitalized each year, and, out of them, about 40 percent go on to use post-acute care. So when somebody is hospitalized in the Medicare program, they are using a lot of services. And there is actually an exhibit at the back of your testimony that shows some of the ping-ponging patterns that go on.

Two, passage of the IMPACT Act a couple years ago was one of the most important pieces of legislation. As patients go in and out of these skilled nursing facilities, rehab hospitals, long-term care hospitals, and home health agencies, they are each getting medical services and rehab services to some lesser or greater degree, but we didn't have a consistent way to measure how complex they were, and the IMPACT Act has given us the tools to do that.

Although, one group that was omitted when we think about beneficiary episodes of care were the hospitals, which is where the episode of care begins and where the communication about that patient's trajectory really ought to begin.

The third key point that I would make is that in the subsequent legislation that has tied quality to payment you have really seen some changes occurring.

So, with that said, I am going to turn to my written testimony. The first part I will skip over, just to make the point that 40 percent of those people who are hospitalized each year are going into the hospital. That was in 2008. More recent numbers by MedPAC have it at 45 percent. So, as our population ages, they are getting more complex. And it underscores the importance of the episode of care and not the silo of care in which they are treated.

One of the most important directives that started a lot of this was the DRA of 2005. The Deficit Reduction Act called for standardized assessment so we could really see to what extent that stroke patient was being discharged from the hospital to a skilled nursing facility versus the hospital to the rehab hospital. If the patients were very different, then that called for different resources, and we might expect different outcomes, but we didn't know that without having standard ways of measuring them. So the DRA led the science to develop those elements based on the consensus and the input of the various clinical communities, the real experts in treating patients.

In 2014, when you passed the IMPACT Act, it gave CMS the impetus to move the standardized elements into the existing assessment tools that are used in each of the four settings and laid the foundation for the quality reporting programs to be more comparable. But we still have four quality reporting programs, and we don't know how complex the patient was at discharge.

Just for a little background about these post-acute care providers: Long-term care hospitals, while they are admitting 2 percent of those post-acute users, most patients have

been in an ICU at least 3 days prior to the admission. The rehab hospital, they are cases that have high needs for physical medicine and rehab, and I think Dr. Worsowicz will speak to that. SNFs are important for that medical care but not that high-level acute care. And home health is one of the backbones of our delivery system.

So I am currently co-directing a contract with the RAND Corporation to implement the rest of the IMPACT Act, and this work is very important. It is one of multiple contracts that CMS has underway to be measuring, to be designing consistent quality metrics. Those metrics are key to setting up value-based purchasing programs or accountable care organizations. Whatever framework you want to put that value into the payment system, you need to understand the impact on the outcome, and the IMPACT Act gave us the foundation to allow that to occur.

So I guess my big take-home point is that tying payments to minimum quality thresholds to ensure that services are appropriate and cost-effective is key to effectively redesigning the Medicare program in a way that ensures beneficiaries have access to the appropriate services they need.

The various quality reporting programs and value-based purchasing programs have moved the dial forward, but you are still operating in silos. And moving forward so that you are looking at a patient's episode of care and not the setting to which they admitted will be even more impactful when tying outcomes to patients.

These are complex issues, and I am happy to take any questions that you may have.

[The statement of Ms. Gage follows:]

Chairman Tiberi. Thank you.

Ms. Wynn, you are recognized for 5 minutes.

STATEMENT OF ELISABETH WYNN, SENIOR VICE PRESIDENT, HEALTH ECONOMICS AND FINANCE, GREATER NEW YORK HOSPITAL ASSOCIATION, NEW YORK, NEW YORK

Ms. Wynn. Great. Thank you.

Good afternoon, Subcommittee Chairman Tiberi, Ranking Member McDermott, and other distinguished members of the committee. I am Elisabeth Wynn with the Greater New York Hospital Association. We represent about 150 hospitals across New York, New Jersey, Connecticut, and Rhode Island. Most are teaching and/or safety net hospitals, meaning that they serve a high proportion of low-income patients.

Greater New York greatly appreciates the opportunity to testify regarding Medicare's pay-for-performance programs, colloquially known as P4P. As providers work collaboratively to implement alternative payment models, such as bundled payments, it is

imperative that the financial incentives to improve quality and efficiency are aligned across the provider sectors.

Successful adoption of these alternative pay models may be the only viable option for hospitals with a high Medicare and Medicaid patient population to keep their doors open, because of the underpayments from these programs. Therefore, we applaud the committee for taking up these very important topics.

The Medicare P4P programs have appreciably advanced hospitals' focus on patient safety initiatives and outcomes. Every hospital now has a dedicated effort to prevent infections, reduce readmissions, and improve patient satisfaction scores. Greater New York supports these efforts through our innovative quality collaboratives, such as reducing readmissions between member hospitals and local nursing homes. We are very proud of the quality improvements that our members have made through these efforts, although we all recognize that there is still a lot of work to be done.

This afternoon, I want to touch on the financial impact of the P4P programs on our hospitals, our concerns with some of the technical aspects of the programs, and opportunities for Congress to improve upon the current framework.

Hospitals are currently evaluated in five different P4P programs, which evaluate hospitals on quality reporting and performance on measures such as 30-day mortality rates for heart failure, 30-day readmissions for knee replacements, or complication rates from infections such as sepsis or pressure ulcers.

Combined, these programs result in an aggregate savings to the Medicare program of nearly a billion dollars or 1.1 percent of hospital payments. Nearly 60 percent of these savings, or over $500 million, is generated from the readmissions program, and 40 percent, or nearly $400 million, is generated from the complications program, known as HAC. Value-based purchasing, or VBP, is budget-neutral to the Medicare program, although it is redistributive among hospitals.

At the hospital level, the penalties top out at roughly 6 percent of payments, but the impact varies by type of hospital. For example, major teaching hospitals incur the largest penalties, at about 1.7 percent of their Medicare payments, followed by high safety net hospitals treating low-income populations, at about 1.2 percent. The higher impact for these groups is due to the disproportionate losses that they suffer from the readmissions and HAC programs.

The key finding from our analytical work on these issues is that some of the P4P programs unfairly penalize hospitals for factors beyond their control.

First, as recognized by this committee in the Helping Hospitals Improve Patient Care Act, the readmissions rates are not risk-adjusted for patients' socioeconomic status or patient risk factors that are beyond the control of the hospital. We applaud the committee for this work on this issue and call on the Senate to adopt similar legislation.

Also, the readmission program penalizes hospitals for their 30-day readmission rates, a timeframe that really is more a reflection of what occurs in the community post-discharge as opposed to the care that is occurring within the hospital.

In the VBP program, 25 percent of the hospital's performance score is based on their patient satisfaction score. Hospitals treating higher percentages of low-income patients are more likely to perform poorly on these measures because they don't have the financial resources to invest in building amenities, like single-patient rooms or modifications to reduce noise.

Another key design problem is that the readmission and HAC programs fail to recognize hospital improvements, so hospitals can continue to incur significant financial penalties even as the rates of these events decline. A full 25 percent of hospitals are always penalized by the HAC program.

Having five different P4P programs also provides an unnecessary level of complexity that is difficult for the average hospital to understand. We strongly encourage you to adopt reforms that consolidate the hospital P4P programs, similar to the approach adopted for physicians, to streamline the programs, balance the incentives, and improve the fairness.

Thank you for the opportunity to testify, and I look forward to your questions.

Chairman Tiberi. Thank you.

Mr. Guenthner, 5 minutes.

STATEMENT OF STEVE GUENTHNER, PRESIDENT, ALMOST FAMILY, LOUISVILLE, KENTUCKY

Mr. Guenthner. Thank you, and good afternoon, Chairman Tiberi, Ranking Member McDermott and members of the committee. On behalf of Almost Family, I am absolutely thrilled to be here today as a participant in the evolution of quality in Medicare.

Almost Family's experiences navigating changes in Medicare span four decades. I have been a member of its executive team for 25 years and its president since 2012. Our cornerstone belief is that the needs of patients must always come first. It is how we operate our business at Almost Family, and it is how we approach the evolution of quality in Medicare.

Value-based purchasing is the natural next step in the evolution of patient-centric Medicare policy, especially when it rewards providers for patient-focused outcomes balanced against the cost incurred to achieve those outcomes. The ideal VBP would redistribute payments to providers not only within a payment silo but also across payment silos, with the goal of getting patients to the best-value care setting for their needs. We

need to change the policy question from how should we pay providers to how we should care for patients. This is especially important in the context of quality discussions.

VBP must address first the measures to be used and, second, how much financial risk providers should bear. In a post-acute VBP, the following simple measures are best: one, hospitalization; two, emergent care without hospitalization; three, restoring the patient's previous level of functionality -- now, this is the measure that is the most important to patients; and, four, the cost incurred to achieve those outcomes.

On financial risk, too little could be ignored by providers, and too much could drive unanticipated outcomes. We believe the sweet spot to balance these concerns is somewhere in the 2 to 5 percent range of provider payments. We would not support more than 5 percent at risk.

Now, I know I am here as a representative of post-acute providers, but I have to object to the unnatural grouping of dissimilar providers currently included in most post-acute discussions. This group runs the gamut from LTACs, which are actually hospitals, all the way to home health care. Home health could be considered the ultimate post-acute care, getting patients back home, but home health also plays a vital role in avoiding acute care, especially for the chronically ill patients.

Some thoughts on chronic care: As your own committee pointed out in your 2015 stakeholder request, chronic illnesses such as heart disease, diabetes, and cancer now account for over 90 percent of spending. We simply cannot solve the Nation's post-acute care delivery and spending problems unless we address chronic illnesses.

We have proposed a number of reforms designed to help keep chronically ill out of institutions and in their own homes, managing their conditions under the supervision of their primary care physicians. To address chronic care needs, we propose closing the biggest single gap in Medicare today, and that is the absence of effective care management and care coordination processes.

Managing chronically ill patients at home helps avoid both acute and post-acute care costs. We think one of the best ways to do that is to bifurcate or split the home care benefit into two pieces, one post-acute and one chronic care, to separately address the needs of those patients at their different stages in their healthcare journeys.

A note on regulatory relief: Sometimes well-intended policies can go awry and require regulatory relief, such as the requirement for a physician face-to-face encounter with a patient in certifying the need for home health services. The statute was fine; unfortunately, it was not well-implemented in regulation.

CMS has fixed some of the problems, but we are left with an over-reported error rate in home health payments. This now has CMS implementing a pre-claim review process that we expect to add significant burden and create unanticipated consequences, not to actually reduce improper payments or improve quality but, rather, to fix documentation

issues that were brought about by subjective regulations. CMS expects to spend about $300 million to address this.

We ask you, please consider legislative fixes to the home health face-to-face and pre-claim review process, and also please address the appeal backlog that -- in a similar fashion, this was done with the hospital appeal backlog some years ago.

One final topic, on payment safeguards. Since 2011, Almost Family has proposed to drive cost savings through a home health payment safeguard patterned after the proven outlier limit, which has saved the Medicare program $1 billion a year. We estimate this equally practical safeguard will save another $600 million a year. And, sadly, while we have been advocating this, $5 billion has gone out of the Federal Treasury, in our view, unnecessarily. We ask, please do not miss this opportunity to capture these savings in your legislation.

Thank you so much for letting me be here today and allowing Almost Family to be a part of this process, and we look forward to your questions.

Chairman Tiberi. Thank you.

Dr. Worsowicz.

STATEMENT OF GREGORY WORSOWICZ, M.D., PRESIDENT, AMERICAN ACADEMY OF PHYSICAL MEDICINE REHABILITATION, ROSEMONT, ILLINOIS

Dr. Worsowicz. Thank you, Subcommittee Chair Tiberi and Ranking Member McDermott and members of the subcommittee.

While I thank you for this opportunity, I hope we are on what I hope is a continuous evolution on quality improvement under Part A Medicare. We need to treat the best way we can the patients you serve and that I serve together.

I will focus my remarks on improving quality and value based on purchasing in post-acute.

For background, currently I am a physiatrist, which is a physician that works in physical medicine and rehab. I am currently the president of the American Academy of Physical Medicine and Rehab, which is a group of 9,000 physicians trained in my specialty working with people with impairments to be at their most independent and fulfilling function with the right medical and functional rehabilitative components.

Like many physiatrists, I work in many, many settings. Currently, I am the chair of the Physical Medicine and Rehab Department at the University of Missouri. I am also medical director of Rusk Rehabilitation Center, which is a joint venture between our

university and HealthSouth, and medical director of our post-acute care initiative at the university.

Physiatrists are well-suited to help direct patients to the right level of care. I have worked in all four settings: in-patient rehabilitation, skilled nursing facilities, acute care hospitals, and long-term acute care centers. I have also served on the board of a home health organization.

If you are depending on the patient, you have to understand these patients are fluid that we serve. Take a patient with a stroke. We have evidence-based guidelines that stroke care needs to be coordinated, needs to be comprehensive, involve the family and other team members. I can take the same stroke patient and, based on their evaluation, the in-patient rehab facility is the best. Another patient with other factors, including their medical, functional, social -- I appreciate the socioeconomic factor -- geographic area where they live and the patient choice, treat them in a skilled nursing facility. Other patients might be treated directly at home with home health. I encourage you to take these factors into consideration as we move forward with legislation.

In fact, I appreciate what Ms. Gage said. Post-acute care starts in the acute care hospital. If we don't place the patient and make that evaluation in the acute hospital, our post-acute programs are bound to fail.

While I appreciate our academy does strongly support value-based purchasing, I can always say quality had been a focus, but it hasn't been until there is financial incentive have I seen that laser-beam focus on readmissions, on hiring people to focus on these issues. So I applaud you on that. I think that is a critical component, and I can attest to that personally.

I will ask, though, that, as we build this focus, realize we have a lot of different programs. I am just a mere clinician out in the field treating patients. I have MACRA, I have MIPS, I have alternative payment models, all these things, and, believe it or not, I actually have to keep up on medicine to care for patients. I would ask you, whatever programs we put in place, we coordinate them; we don't sub optimize what we are doing and restrict, as with so many regulatory issues I am hamstrung on what I can do or I am chasing incentives that may not align with others.

Withholds I appreciate. Coming from a small, rural area, I will ask, carefully consider what are the withholds and how you put them into play. I would be concerned that if our small-margin centers, if they take too much of a withhold initially, is that an access issue if they go out of business? I am for quality, but I am also for having the access for my patients and giving time to make adjustments.

Medicare spending per beneficiary -- once again, I can go back to the cost and quality. We have already seen what it has done. I am in favor of this as one metric but not as a standalone metric. I think we do need to have risk-adjusted metrics, looking at

function, looking at activity levels for patients, so we purchase wisely the services that we are for our beneficiaries.

I was asked to talk some regulatory relief for physicians. Some of those can be just straight administrative paperwork issues. Also, as well, having timing of when things are signed may allow some regulatory relief; the utilization of non-physician providers, care extenders, or physician extenders to do some of the work that we need to get done.

Last is to work on those deadlines. I would be remiss if I didn't say this. I know 2015 was the year of physician reform. 2016 is now looking at facility reform. I would ask, in 2017, some GME reform. If we don't train providers in these settings, how can I or any provider in the future work within these settings effectively?

With that, I thank you. I appreciate the fact that this is a true team of legislative, physician, researchers, administrators working together to make the best for the patients we serve. Thank you.

Chairman Tiberi. Thank you.

All four of you provided some really good testimony. We really appreciate it.

If each of you could put yourself in our shoes, what three principles would you name as we try to legislate pay-for-performance? Think about three principles that we could use in legislating that issue.

Ms. Gage?

Ms. Gage. Three principles. Well, one principle that has underlined a lot of the past work -- you know, I work in the post-acute care payment arena and quality measures development, and having equitable payment rates is critical to having a cost-effective use of the trust fund. That said, equitable payment rates are only equitable if the patients are equivalent. So understanding the outcomes is key to any payment modification.

A second principle is actually tying the quality initiatives to payments. Because, as we have seen and as Dr. Worsowicz mentioned, until readmissions were tied to financial penalties -- and we have seen those in each of the programs -- there have been QRPs, but they haven't really moved the dial.

And the third principle I think is keeping the patient in mind. Since the ACA passed, we have had a lot of talk about patient-centered care and about the patient's preferences and needs. And all of these patients, at least those that are discharged from the hospital to post-acute care, have a range of complications -- medical issues, functional issues, cognitive factors complicating it. So really designing systems that allow for adjustment, given those mix of factors, will ensure access to appropriate services.

Chairman Tiberi. Thank you.

Ms. Wynn?

Ms. Wynn. So the three that I would put forward for your consideration is, one, a program that is streamlined in some way so that providers don't suffer from measure fatigue. In the hospital sector, we are reporting on over 90 different measures now, and we are spending all of our time chasing the measures, and that really detracts from time that could be spent on quality improvement efforts themselves.

A second principle would be to ensure appropriate risk adjustment that really will ensure buy-in from the provider community that the measures are fair.

And then the third, I would say, is to focus on issues that are within the control of the provider so that it really is focused on provider quality as opposed to other issues in the community.

Chairman Tiberi. Thank you.

Mr. Guenthner. So I think, from our perspective, first, patients matter more than providers. We always have to keep that. There we go.

Chairman Tiberi. Thank you.

Mr. Guenthner. My first item is patients matter more than providers. We have to design processes and systems that address the needs of patients. And we really need to be talking much more about how we do that than about how we pay individual provider categories.

Number two, with all deference, hospitals are incredibly important; health care does not begin when you get admitted to a hospital. Health care begins in the patient's home, and it ends in the patient's home. And I know we have some statutory things going on around that, about what a spell of illness is and how it only begins when an in-patient admission begins. We take huge exception to that and would love to see this much more focused around where the patient needs to be.

Number three is around value. And value is not an item; value is a relationship. Value is the relationship between the quality and the cost to produce that quality.

Chairman Tiberi. Thank you.

Dr. Worsowicz. I agree, care is not a building, it is not a bricks and mortar, it is a process. No matter where this process happens, the key is to get what the patient needs service-wise to them. And we have built these silos. Think about process.

Second is quality and function. Function is part of quality. Remember that. We got to have that.

Third is payment. When you look at payment, think, what is the long-term ROI? Is the patient at home, not in a facility? Is the patient able to return to work, now a taxpayer? Is the patient able to do enough that their loved one isn't out of work caring for them?

So when we talk about pay and money, what is the long term on it? We have bundled payments. Is it 30 days? Is it 60 days? Is it 90 days? Is it 2 years? The issue is, what is it? I don't know.

Chairman Tiberi. So one more question for all of you, kind of along the theme that you all have been discussing. We all share this idea the best quality at the lowest possible cost to Medicare and its patients.

CMS gathers all this information from all of you. We have access to it, you have access to it, CMS has access to it. Some of my family members who are on Medicare, they don't have access to it. So if someone has a stroke, needs to go to a rehab facility, how do they measure quality? How do they measure cost? How do we get them engaged and their family, me, to understand, as a loved one, what is best for them and their needs? How do we make that connection?

Ms. Gage?

Ms. Gage. Having worn those shoes, despite being a researcher, those are very difficult questions.

The easy answer is one could go to the CMS Web site and look at the hospital compare and the SNF compare, et cetera, to see whether the organizations in your community have decent quality ratings based on the composites of the measures that are there.

Alternatively, speaking with your physician and the people that you know and trust is another major source of information. But often we don't really know what to look at. We don't know that nursing ratios are actually quite important, know that if someone isn't turned they could end up stroking in the hospital. So it is a very complicated issue.

I think CMS has done a lot over the last 5 years to engage stakeholders, bring them to the table. Some of the work that I am doing with them is trying to identify stakeholder preferences. What would they like to see incorporated in exchangeable information? What would they like to know when their loved one goes home from the hospital? What is important? And some of those factors have nothing to do with insurance coverage. Some of them are food in the fridge so you don't end up back in the hospital dehydrated.

So it is a tough area.

Chairman Tiberi. Thank you.

Ms. Wynn?

Ms. Wynn. I would agree with Dr. Gage. And I would just add that I think we are really at almost kind of a nascent stage in being able to pull together the information on quality, on cost, on other factors that policymakers may be interested in, but getting at the heart of what is the patient interested in and patient preference. Working with the physician to identify what is the appropriate care setting for them to be discharged into, is that a SNF or is that home care, based on their own, you know, circumstances and the home supports that may be available to them.

And I think the other, you know, area that a lot of work is going on right now is on improving the communication channels between the different silos within the provider sectors. So as the patient transitions from whether it is a hospital to a rehab facility or rehab to SNF, ensuring that both the hospitals, the nursing homes, the home health agencies, the rehab providers understand what the capacity is at that next level of care to care for the patient, so that we make sure that patients are really discharged to that appropriate care setting.

Chairman Tiberi. Thanks.

Mr. Guenthner. Not to oversimplify this, but I think the best way to find out what is important to beneficiaries is to ask them. And I am really confident that the average Medicare beneficiary, when they have an exacerbation or acute care episode, is exceptionally interested in restoring their level of functionality and getting home.

Chairman Tiberi. Can I interrupt you, though?

Mr. Guenthner. Yes, sir.

Chairman Tiberi. Here's what I mean. So my mother-in-law has a stroke. She is in a hospital. She is going to be discharged from the hospital. The doctor says she has to go to a rehab facility. How do you choose the rehab facility?

Mr. Guenthner. So I think, in our view, in that situation, the key to this is to get in front of that disease state. I think when the patient, particularly a Medicare patient, who is aged, is in an unhappy place because their illness has progressed. They have waited too late to begin to think about engagement in their own care. We have to get in front of these disease states.

We have to get in front of every chronic disease state that we can and engage the beneficiary in advance of that stroke, in advance of that acute care episode. Because, at that point, with the clinical illness, the cognitive implications, frankly the depression, which is a major factor in illnesses in the elderly, that goes along with it -- if you think about this in the context of your mother or your grandmother, what do they want? They want their life back.

Now, they may not get it back because their disease state may not let them get it back. But if they can't get their life back, then they are going to want the best quality of life that they can get to deal with their disease state.

And we shouldn't rely on my testimony to answer that question. We should find that answer. And we should have some process to engage beneficiaries, the patients themselves, before their disease state advances, so that we can make sure we have a good measure of that.

Dr. Worsowicz. I am happy to talk with you afterwards for your mother-in-law and help guide you. First of all, I hope she has a physiatrist that is seeing her to help with it.

But you are right on. This is what I do every day. I see people in the acute care hospitals, and they say, I want to go to the best place, I want to get the best there is, and, of course, they listen to me because they trust me. I am that good -- no. Actually, you are exactly right. That is what perplexes us everywhere.

A, I think the area of care coordination needs to be driven home. Because I may go to a skilled nursing facility at that point in time and it is the best for me because I can't take the physiologic stress of 3 hours of therapy and I could cause harm to you by sending you to the IRF at that point. The same as if you go to the IRF, do the skilled nursing. We are still siloed on coordinated care. You need to incentivize to coordinate that post-acute care for your mother-in-law. And if she doesn't go to the right place the first time, we are incentivized to do the right thing by her.

Second of all, you are taking a big leap of faith if you think the providers in an acute care hospital know the quality of where they are sending people. That is a big factor. I can tell you they don't. That is why you have 8 million different liaisons in hospitals saying, we are the best, we are the best, we are the best. We need to develop risk-adjusted metrics and scorecards so I can grade you to know that, hey, we are sending her to the best.

Third, your mother just had a stroke; you are not going to hear one-tenth of anything I tell you. So remember that.

We have to work on those systems. Coordinate the care, A, build that in. Second, let's develop scorecards or a way to meaningfully measure the care you get. And I would also not think that every IRF is not the same. Every SNF is not the same. You have a wide variety of services. So I could send you to one versus another and get totally different doses of therapy, doses of medical coverage, doses of social care.

If we had 3 hours -- I will talk to you later, but --

Chairman Tiberi. Yeah, we have an opening on our staff for a doctor. We would love to have you apply.

Dr. Worsowicz. Yeah, there you go.

Chairman Tiberi. Thank you all.

Dr. McDermott?

Mr. McDermott. Thank you, Mr. Chairman.

I would like to change the focus just here a little bit.

Ms. Gage, do you have an advance directive?

Ms. Gage. Do I have to admit this publicly?

Mr. McDermott. You don't.

Ms. Gage. I have no children, though.

Mr. McDermott. Ms. Wynn, do you have an advance directive?

Ms. Wynn. I do not.

Mr. McDermott. Mr. Guenthner?

Mr. Guenthner. No, sir.

Mr. McDermott. So all four of you --

Dr. Worsowicz. I do. Yes, sir.

Mr. McDermott. You do?

Dr. Worsowicz. Yeah. And my wife has a pillow too.

Mr. McDermott. All right.

Now, the reason I raise this issue is that we all know that about 70 percent of healthcare costs occur in the last 6 months of life. You can argue about the figures exactly, but that is sort of roughly what we have been able to put together.

And Mr. Guenthner talks about listening to the patient and what does the patient want and so forth. And what I have trouble putting together in my mind is, how much do you think having an advance directive or lack of an advance directive plays into the kind of care that a physician or whatever provider puts forward?

I mean, how often does somebody look at those advance directives and say, this is what they want, and we are trying to get them over to here, but they are never going to get there, they are probably going to get over here. And maybe they don't want us to try to get them over to there, which is 100 percent or 70 percent. As you say, you can put them into a care situation and give them 5 hours of therapy a day and wind up with a patient who says, God, leave me alone, I feel rotten.

So how does the advance directive play into that? Mr. Blumenauer put through a bill, Mr. Levin and I put a bill in 25 years ago that everybody in Medicare ought to file an advance directive, but we have never gotten above 20 percent in the population. And we are about there today, with three out of four don't have one. That is sort of reflective of America, where we don't get people to write wills either. But advance directives are even lower than writing wills.

So how can you develop care -- the physicians, how can they deliver care when they don't know what the patients want?

Ms. Gage. I am not a physician, but I have worked on some of the issues. The joint commission for hospitals had directed the inclusion of the identification of whether somebody had information in their chart on their wishes or their surrogate wishes, and CMS has worked that data element into some of the assessment tools.

That said, as a daughter-in-law, I have seen that we have our wishes, sometimes we left them at home in the living room, sometimes they are in the chart. You come into the emergency room; the doctor does all that is possible regardless of what is in the chart.

So advance care directives appear to be a sensible approach, but I am not sure they are the most effective way of communicating patient wishes.

Mr. McDermott. So you are really suggesting that doctors should be the final deciders of everything. They have the power. You are there, you put yourselves in their hands. I mean, having been a physician, I realize people come in, say, here, take care of me. And that is what you are saying.

Ms. Gage. I am not saying that that is a measure of quality or an ideal situation. I think that is the experience that happens quite frequently.

Mr. McDermott. It is not what happens in Mr. Kind's district, where about 80 percent of the people have got advance directives, because there was a concentrated effort by the medical community to do that.

Doctor?

Dr. Worsowicz. Yeah. Actually, the type of work I do, the advance directive only comes into play with severe brain-injured patients and severe stroke patients. Otherwise, it is what does the patient want and what is the goal.

Part of my goal is to describe to them what is the physiologic capacity to meet that functional goal and the impairment that they have and how they would attain that goal. I don't disagree with you at all. We tend to spend a ton of money at the end of life. I want to spend a ton of money to preserve quality of life, is what I am working on.

So, in my practice, advance directives come into play only in those severe cases and that they don't maybe have a health surrogate.

Mr. McDermott. Thank you, Mr. Chairman.

Chairman Tiberi. Thank you, Mr. McDermott.

Mr. Roskam is recognized for 5 minutes.

Mr. Roskam. Thank you, Mr. Chairman.

I just have two quick questions.

Dr. Worsowicz, could you give me a sense of how the IMPACT Act interacts with any subsequent proposals to make changes in this area?

And so let me give you the backstory on my question. I had a meeting with folks in my constituency, and they are concerned and they say, look at the IMPACT Act. The data has not yet to be determined or yet to be collected or whatever, there is some that has not yet happened, and now something new is being contemplated. And, you know, they didn't say it this way, but what they are telling me is, hey, you know, cut us some slack here, you know?

And I don't know enough off the top of my head about how these things interact. Are they over-characterizing that? Are they characterizing that accurately? Is there a legitimate beef? What is your perspective?

Dr. Worsowicz. I imagine you get both ends of the spectrum that walk into your office, yes/no, yes/no. Some of the scientific data from the IMPACT Act -- I will ask my panelists -- is yet to be fully developed to say what has been -- have we moved the needle to where we want to move the needle.

Mr. Roskam. So is the data already being collected on the IMPACT Act, just so I am clear?

And anybody else from the panel, can you just educate me on that?

Dr. Worsowicz. I will let the experts.

Ms. Gage. Some of the concepts that were in the IMPACT Act are being collected currently. They were moved right into the assessment tools in each of the different settings.

Mr. Roskam. So folks who were in talking to me, what were they referring to that is going to happen next month? Do you know off the top of your head?

Ms. Gage. There is ongoing work to continue development of additional items.

Mr. Roskam. Okay.

Ms. Gage. And that work is -- well, there are different timelines going on depending upon whether they were talking to somebody about quality measures or data element development. But, this month, the first pilot test went live with some of the additional measures in the IMPACT Act. But CMS had already moved forward some of the directives from the original set.

There are about four or six different conceptual domains. And so moving items in right away -- for example, function is now in a standard way collected in the rehab hospitals, the SNFs, the home health, the LTACs. But the other metrics that you might want to use that might also be in the area of function are still possibly under development. Certainly, in the area of cognition, there is additional work being done.

Mr. Roskam. Okay. That is helpful. Thank you both.

Ms. Wynn, do you have a sense, you know, being active with the Hospital Association and so forth, are there some regulatory tradeoffs that CMS or Congress could offer that are reasonable, that make sense, that don't jeopardize patient safety, you know, et cetera, et cetera, et cetera, that are just good commonsense things that your members would say, look, we can live with this change in reimbursement if you cut us some slack over here? Do you follow my question?

Ms. Wynn. Yeah, sure. So there are several different areas. One I would offer, especially as we move towards value-based payments where the providers are taking the risk, is on medical necessity review, so chart reviews. They are very administratively burdensome on the hospitals to provide the paperwork to the reviewers, and we commonly have disagreements with the reviewers --

Mr. Roskam. I get it. So the argument is, look, we are assuming the risk here; what is this whole review process?

Ms. Wynn. Right. So if we are taking the risk for the total cost of care of a Medicare beneficiary, then it is up to us to decide whether or not there should be an in-patient admission or whether or not they should be treated in an ambulatory care setting. Let us decide the best place for the patient.

Mr. Roskam. That makes perfect sense to me right now.

Has that largely been socialized? Are more people talking about this than I realize? Is this one of those things everybody is talking about this and I just don't know it?

Ms. Wynn. Certainly within the hospital community we are.

Mr. Roskam. Okay. That is helpful.

Okay. Thank you.

Thanks, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

Mr. Thompson is recognized.

Mr. Thompson. Thank you, Mr. Chairman.

I was interested in the discussion as it went along regarding patients in the mix. And somebody said that there should be a financial penalty for readmissions. Mr. Guenthner, I would like to hear from you on what responsibility does the patient have in this.

One thing I hear from my providers is they do everything they need to do on their end, they send them home, and then they don't do what they are supposed to do, they come back, and the hospital gets dinged.

Mr. Guenthner. Okay. I might have finally figured out the microphone.

So, you know, I think that patient compliance is always an issue in medicine. We see it in home care. We go into the patient's home, we make the assessment, we give the advice, and patients don't follow it. And this is America; patients don't have to follow it. And sometimes they can, and sometimes they don't.

We think that -- again, I sound a little bit like a broken record, but the trick is to get in front of the high-risk patient's chronic conditions and to engage before the acute care episode happens and see if we can get closer.

Mr. Thompson. That may work well in some communities, in some populations, but in others it doesn't. How do you crack that nut?

Mr. Guenthner. If you could expand just a little on those that you are concerned that it doesn't.

Mr. Thompson. If you have a community that is maybe not as inclined to follow healthy procedures or a community that doesn't have access to quality food, for example.

Mr. Guenthner. Okay. So one of the places we see this in our practice is, in particular, with the dual-eligible population, where income levels tend to be lower, education levels tend to be lower, more socioeconomic issues going on in that community.

And one of the things that we have talked about in some of our previous submissions to the committee are the need to really get at that coordination of benefits with the dual-eligibles and to bring some of these socioeconomic factors into play. We can't always --

Mr. Thompson. I don't know if we are going to figure it out today, but I think that is something that needs to be in the mix, because I don't think you can put the whole load on the provider. We need to figure out how to either get every population to do what they are supposed to do --

Mr. Guenthner. Right.

Mr. Thompson. -- or figure out how to mitigate that financial penalty.

One area that I think is interesting -- and this whole VBP is based on delivery of appropriate care faster and more efficiently. And with the advance in diagnostic testing, I think we have an ability to be able to bring diagnostics into the mix to help speed that up.

And I guess, Ms. Gage, I would like to know, what do you think we should do to make sure that hospitals and other providers are using the types of advanced technology that will really drive all the outcomes?

Ms. Gage. Hospitals are receiving some incentives at this time with the movement toward ACOs and bundled payments and value-based purchasing programs where the market is now giving them the incentive to have the best technology available. Some of the hospitals are starting to move into telemedicine, even though it is an unfunded Medicare benefit. And I think we are seeing some changes in the market in response to achieving the best outcomes. Competition is starting to drive what is delivered on an outcome basis.

Mr. Thompson. And you hit on the other thing I was going to ask about, and that is telemedicine. I have been involved in that for a long time. And it hasn't been necessarily beneficial in the fee-for-service landscape, but I think it fits well into value-based purchasing.

And, Ms. Wynn, do you see a potential for growth in telemedicine under the VBP model? And is there anything we should be doing to enhance that?

Ms. Wynn. Sure. Thank you for the question.

We are seeing, you know, telemedicine I think historically has been thought of as more of a presence in the rural areas, and we are starting to see more and more our members in

inner city urban areas using telemedicine to provide specialist care and ensuring access to those higher acuity services for patients. So I think payment policies that can continue to enhance those services would be one thing, and then that is another area for regulatory review as well.

Mr. Thompson. Well, I would submit that not only does it work well in underserved area, you know, rural or urban underserved, but I think there is potential benefit if we were able to grow this delivery of medicine and use it more and figure out how to make it work and provide you guys the opportunity.

Thank you, Mr. Chairman.

Chairman Tiberi. Thank you.

Mr. Smith is recognized.

Mr. Smith. Thank you, Mr. Chairman.

Thank you to our panel today. I appreciate your dedication to these issues that are certainly important that we ensure dollars are well spent on quality care, and I appreciate your expertise.

Ms. Wynn, providers often site Medicare's conditions of participation as being outdated and burdensome. Which of these requirements would you say are most problematic for hospitals?

Ms. Wynn. I think I would follow up with your staff on those issues.

Mr. Smith. Okay. I appreciate that. I know that there are a lot of issues here, and I know certainly observing the various situations over the last several years, my own grandmother, for example, I am glad there are some great providers out there and facilities that they will look to to offer great services.

Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

Mr. Davis, you are recognized for 5 minutes.

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

I certainly appreciate this hearing, and I thank all of the witnesses for being here.

We have talked a bit about safety net institutions and population groups that might frequent them. And as we move toward standardizing treatment, as we attempt to

standardize payments, let me ask you, Ms. Wynn, how do we make sure or try to make sure that we are treating the safety net institutions fair?

And I know that fairness is like beauty, in the eye of the beholder, but how do we try and do that?

Ms. Wynn. So I think the most important thing is making sure that, especially in payment penalty programs, that the measures are risk-adjusted to recognize the socioeconomic issues and sociodemographic issues that are facing the patients so that those hospitals aren't unfairly held accountable for some of the patient factors.

The second thing is making sure that the supplemental payments, or DSH payments, that are paid to the providers, they are critically important, whether they are Medicare payments or Medicaid payments, to really the financial viability of the financial institutions. The ACA included some very significant cuts in funding in those programs, and, you know, as a representative of many of those institutions, that is an area that we are very concerned about as we look forward over the next few years, is maintaining those funds so that our hospitals can maintain their operations and access to services for the communities that you are discussing.

Mr. Davis. Let me just ask if other members of the panel would like to comment on that question?

Dr. Worsowicz. I think the risk adjustment is critical. I think some of the DSH payments, I am not as positive. Make sure the post-acute care providers that care for these individuals have the risk adjustment. The key is to have the payment follow the patient in these areas.

We brought up the other issues of big on the use technology, telehealth. Make sure that people are able to be provided their medicine as they go home and they get instruction in the home place.

I would argue, if you have a family member, elderly, ask them for their med list. There is no way they can understand their med list if I spend an hour and a half. So we need to put in some safety net procedures to assist them, once they leave the hospital, into either the hospital setting, skilled nursing setting, rehab setting to make sure that is following them.

Mr. Guenthner. I think my answer to that, Congressman, really gets back to the need to coordinate benefits between title 18 and title 19 of the Social Security Act. Patients, if they, in fact, are safety net patients, don't understand the difference between Medicare and Medicaid and don't care about the difference between Medicare and Medicaid. They believe that their government, the promise made by all of us to care for these patient populations, is going to be handled and there is going to be folks looking out for them.

And it really does come down to the need to coordinate care. A lot of providers have to spend a lot of time trying to figure out for a given patient, now, is this a Medicare benefit? Is this a Medicaid benefit? How do I think about that, and how do I coordinate those? And this may be way outside the scope of this committee's deliberation, but ultimately bringing those benefits together we think is absolutely critical for the future of the healthcare system.

Mr. Davis. Ms. Gage?

Ms. Gage. I think you approach it in terms of the payment design. Typically, the lower income populations have more healthcare complications for whatever reason -- the food, the genetics, whatever is behind those differences. And so as Dr. Worsowicz said, risk-adjusting the outcomes and risk-adjusting the payments, that is one way of correcting for the higher needs of those more severely ill populations.

But, secondly, you raised the issue of the public hospitals and the provider serving the underserved areas. So when you think about a payment system, there are two types of factors at play. There are the case mix factors, where you adjust for the patient differences, but there are also often setting-specific factors that recognize the fixed costs of different types of providers. And those fixed costs are important, because different types of patients need different types of resources. So addressing both of those in a payment design can help.

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

Chairman Tiberi. Thank you.

Ms. Jenkins is recognized.

Ms. Jenkins. Thank you, Mr. Chairman.

And thank you all on the panel today. Countless studies from universities, health insurers, and MedPAC state that the geographic in costs for Medicare is in the post-acute care setting and that those costs vary a great deal. In my district in Kansas, most of the post-acute care providers are rural, and they are typically low-cost options compared to the national average for care in the post-acute care setting.

There is a section in the Medicare Post-Acute Care Value-Based Purchase Act, 3298, that measures cost at a geographic level.

Given the fact that Kansas is a relatively low-cost rural State, I have just a couple of questions maybe for Mr. Guenthner and Dr. Gage. How will this geographic measure benefit Kansas providers, and how will this bill either negatively or positively impact rural PAC providers?

Ms. Gage. I hesitate to answer, because I haven't looked at the specific legislation that you are referring to.

Ms. Jenkins. Okay.

Ms. Gage. But, typically, often there are rural adjustments to recognize the differences in the cost factors in the larger rural areas. They are typically setting-specific. And I am not sure what went into that bill, so --

Mr. Guenthner. Well, first, I want to really thank you for this question, because this is a topic of great interest to us. We talked about in our program integrity proposals, and we see it significantly in our ACOs. We manage 15 Medicare ACOs through our Imperium subsidiary, and there is, in fact, great variation in healthcare spending across the Nation. It is not limited to post-acute care. It is more prominent in post-acute care.

In home care in particular, we see very dramatic differences, really around the supply of providers relative to patient populations. And so when I talked in my oral testimony about the program safeguard idea, that idea is around looking at the relationship of utilization to a patient population. If I was a taxpayer in Kansas, like I am in Kentucky, it disturbs me to see, for example, 3-1/2 times the home-care use in one State that I see in another State. And then when I go look at what is causing that and I see the supply providers relative to patient populations -- I want to tell you a fact, and you can decide if this makes any sense to you. In Chicago, the metro area, there are 664 home-care providers. In New York, the metro area, there are 61. Not surprisingly, home-health utilization in Chicago is a lot higher than it is in New York. And this is at the core of how we control variations in utilization pattern. We believe strongly that differences in the supply of providers create different normative standards in a community. Because there are so many providers competing for a number of patients, the definition of medical necessity moves. And what is medically necessary in New York and what is medically necessary in Chicago become different measures, and that is really not how this Medicare benefit should be administered. And thank you for that question.

Ms. Jenkins. Sure.

Any other feedback from the panel?

Ms. Gage. And that is why outcomes measurement is so important. We do see a lot of variation associated with supply, but understanding whether the patient is getting more services because they are more medically complex or more functionally impaired identifies the inappropriate variation.

Ms. Jenkins. Okay. Very helpful.

Yes.

Dr. Worsowicz. They hit on the term "medical necessity." Be very careful when you use that term. As we have seen it based on number of providers, it can also mean things for different places. I have seen patients in the ICU where the note says "medically stable." That is medically stable for the ICU or whatever. We often in the post-acute arena get denied in different settings because they are medically stable. Why do they need to be there? That is in any of the four settings I have seen; there is a functional issue that goes along with that. So I would measure that. And, again, it doesn't answer your question, but someone brought up "medical necessity," huge term.

Ms. Jenkins. Right.

Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

Mr. Pascrell is recognized for 5 minutes.

Mr. Pascrell. Thank you, Mr. Chairman.

Dr. Gage, given your involvement, extensive as it is, and the development and analysis of a number of different value-based payment models, one of the things we are looking at very carefully, how do we best find what you and I could consider the appropriate balance of the number of measures to ensure that they are truly reflective of quality and patient experience but also not overly burdensome? How do we get to that point, or do we?

Ms. Gage. I think we can. And I think that the fields, the science of quality measurement, has evolved to the point where, instead of developing measures that could be used to make sure that someone was receiving adequate care, which is how a lot of the quality measurement programs grew up, we can be looking at those factors that we start with the never events. And the hospital QRP incorporated some of those. But there are also other events that are preventable: decline in medical issues like pressure ulcer growths --

Mr. Pascrell. I am sorry? I didn't hear that. A what?

Ms. Gage. I am sorry?

Mr. Pascrell. I didn't hear the last phrase you used.

Ms. Gage. Oh. Decline in medical conditions, such as growth in pressure ulcers, that could have been avoided.

Mr. Pascrell. Right.

Ms. Gage. In the area of function, the expected improvement or, for a frailer population, the maintenance of one's mobility and self-care. So thinking about those key metrics that a patient is really going into the hospital to have cared, have treated, is one way of reducing -- we see all sorts of measures in the ACO program and all sorts of measure options in the PQRS, et cetera, but we really need to start a discussion about which ones are really the sentinel medical outcomes, the sentinel functional outcomes and the cognitive factors.

Mr. Pascrell. All right. Okay.

There's been some disagreement, as you know, we all know, between Democrats and Republicans on the issue, likely there will be more in the future. I believe that the shift we have seen in our healthcare system away from fee-for-service toward a value-based system, quality-driven healthcare system, is a truly bipartisan idea -- not Democratic idea -- a bipartisan idea. So the Affordable Care Act laid the foundation for building a healthcare system that rewards quality. We have a long way to go to that end. There are no two ways about it. It rewards quality. It rewards the outcomes and smart spending rather than the volume of services provided. This is what we started out to do, and we have a long way to go. There are no two ways about it.

So the Center for Medicare and Medicaid Innovation -- we were talking about this this morning, ironically, in the Budget Committee -- is testing a number of payment models that improve quality and lower the cost for the patient in the system.

Medicare has made, I think, great strides in rewarding quality. And earlier this year, HHS met the goal of tying 50 percent of Medicare payments to value by 2018. So we are moving in the right direction if the system is whole.

HHS is working toward the more ambitious goals of tying 85 percent -- 85 percent -- of fee-for-service payments to the quality by the end of 2016. That is us, right? And 90 percent by the end of 2018.

This shift represents, I think, a fundamental change to the way our healthcare system operates now. So it is to be expected that there will be some growing pains and that some of the models we test will not turn out the way we hope. And maybe give us some examples, anybody.

What we started out to do, it didn't wind up so pretty at the end. But this is what we went through with Social Security. This is what we went through with Medicare. This is what we went through in Medicaid. And when you have both sides working together, it would seem to me, Dr. Gage, that we would have a better shot of making some changes that we all could live with, Mr. Chairman.

So what do you think, Dr. Gage? That is a toughie, but let's try it anyway.

Ms. Gage. I think that is out of my expertise, and you showed with the IMPACT Act, the important work that can be done in pulling together a bipartisan bill, so I am sure that you have the wherewithal to do so.

Chairman Tiberi. Thank you. The gentleman's time has expired.

You are challenging me today, you and Mr. McDermott, really engaged in the Affordable Care Act. But I have been nice, very nice.

Mr. Pascrell. It is our human way.

Chairman Tiberi. Mr. Paulsen, you are recognized for 5 minutes.

Mr. Paulsen. Thank you, Mr. Chairman.

I thank all of you for being here today.

Ms. Wynn, I just want to follow up on some of your testimony that you just had regarding the pros and cons of the current pay-for-performance programs for hospitals. I recently held a roundtable as well of hospitals in Minnesota. And like you, they have some of the same concerns about the duplicative and burdensome design of the programs. And one concern that they raised is the readmissions in hospital-acquired conditions programs are solely focused on payment penalties, and they don't give hospitals the opportunity to improve.

So is this a concern to hospitals in New York as well, and do you think hospitals should have the opportunity for a payment bonus that could be provided for good performance, for instance, in avoiding complications and readmissions?

Ms. Wynn. Yes. Thank you for that question. This is an issue that is foremost on the minds of our members as well. And maybe, if it is helpful, you know, one thing to think about is the way the penalty programs work for both readmissions and the complications is that there is no credit that is given to the industry if they do improve. And so, in order for a hospital to work its way out of the bottom quartile or the penalty phase within the HAC program, for example, they would have to improve -- not only just improve, but improve faster than every other hospital across the country, right, because the bottom quartile is always penalized.

Mr. Paulsen. Right.

Ms. Wynn. So I think the fear on the provider side is often that these programs are really just ways of, you know, cloaking payment cuts as opposed to really incentivizing high-quality care.

Mr. Paulsen. Okay. And I have also heard from hospitals back home that the readmissions in hospital-acquired conditions programs make significant payment

adjustments based on a very narrow number of conditions. So, therefore, small changes in performance in these limited categories have a disproportionate negative impact on payment.

Is this, again, a concern for hospitals in New York too? And should the payment impact on a hospital with higher rates of complications be required to be proportional to the actual financial impact of the complications?

Ms. Wynn. Yeah. So, within the readmissions program, one of the major issues or design flaws that we see with the program today is that the savings to the Medicare program from the readmissions themselves is a fraction of the penalty that is being imposed on the hospitals through the penalties.

So, for example, on hip and knee replacement readmissions, the penalties that are being placed on hospitals are 20 times the size of the payments that Medicare program is making to the hospitals for those actual readmissions.
It feels like a very punitive penalty.

Mr. Paulsen. Right. And for those same number of limited complications and readmissions, I mean, they don't reflect the vast types of patients' conditions that your hospital treats, which you alluded to before. In your opinion, does this limited approach also restrict a true evaluation of what a hospital's performance is, then, essentially?

Ms. Wynn. Yeah. And one of the issues, and I appreciate you raising it, especially within the hospital-acquired conditions world is that these are rare events, and we would expect them to be rare events, but they can also randomly occur, essentially. And so when you are trying to get a precise measure of random variation, you can end up conferring very significant payment penalties for providers who really don't have a statistically significant difference in the quality of care provided at hospital A versus hospital B.

Mr. Paulsen. Is there a program in New York that uses a more comprehensive definition of those types of complications and readmissions for payment adjustments in New York?

Ms. Wynn. There is not, actually.

Mr. Paulsen. Okay.

Ms. Wynn. In New York State, there had been a program through the Medicaid program, but that was eliminated 2 years ago.

Mr. Paulsen. Okay.

Well, Mr. Chairman, just to follow up, it seems like the work that is going on in New York or in Minnesota, from what I am hearing from my hospitals, it shows that there are providers and health plans in States out there that are trying to find ways to

make the healthcare system more efficient and effective certainly and not trying to tie the healthcare system up in knots, but they are focusing on the outcomes that are high impact, that there are clinically credible outcomes that we can focus providers around to, essentially to achieve very substantial and sustainable improvements for patients.

I know that Representative Marchant is not here. I think we can learn a lot from these local initiatives. And we are going to be introducing legislation that will streamline the readmissions in hospital-acquired conditions program into one easier to manage program so it will include providing both penalties and bonuses, computing penalties and bonuses that are proportional to the financial impact of the readmissions and complications, and then focusing on readmissions and complications that are actually avoidable, rather than just punishing our hospitals for things that are essentially outside of their control, and doing that in a budget-neutral manner at the same time containing a very clinical and credible method of risk adjustment.

So I disagree with some of your comments. And maybe we can continue to follow up on that and proceed from there.

Ms. Wynn. We would be very interested in speaking with you about that.

Mr. Paulsen. Thank you, Mr. Chairman.

I look forward to working with you on that as well.

Chairman Tiberi. Thank you, Mr. Paulsen.

I would like to recognize a leader in the value-based purchasing area. And, by the way, congratulations on those Badgers beating the SEC on Saturday. Just saying, Mr. Kind.

Mr. Kind. We will take it, especially early in the season. So thank you, Mr. Chairman, for that recognition.

First of all, I want to commend the panel today. I think your testimony has been very helpful and very good.

Mr. Chairman, thanks for teeing up this hearing.

I think this is the critical budgetary issue that is really facing this Congress and future Congresses for a long time. It is healthcare reform. It is healthcare cost, which is really driving a lot of the budget decisions around here: the fact that 70 million Americans, the baby boomers, are now retiring and entering Medicare and the challenges that we are facing and how we best address that.

And I think there is consensus, as you probably heard on the dais here today, that there is a lot of alignment of interests of how can we align the healthcare delivery system so we get better outcomes at a better price. It is as simply put as that. And you guys are

operating in this field right now. We are going to have to rely on your feedback and testimony like today in order to steer us in the right direction. And it is going to be a challenge.

And that is why I was happy, as Chairman Brady pointed out, to introduce with him and working with Chairman Tiberi as well the Post-Acute Care Value-Based Purchasing Act, because, as you mentioned in your testimony, Ms. Gage, when 40 percent of Medicare and hospital-based patients are going to enter the post-acute care setting, this is a huge area that also is going to require our attention on, how can we incent the development of quality measures and then align the payment incentives the right way so we are getting better outcomes in the post-acute care center for our patients that is also fair to the providers?

Mr. Guenthner, I don't know if you or Almost Family have had an opportunity to take a look at the legislation we have introduced yet. But if you had, do you have any recommendations right now, any glaring things that stand out for you right now that you would bring to the committee's attention on what we ought to be more focused on or try to avoid some unintended consequences of what we are trying to accomplish?

Mr. Guenthner. Well, thank you for the question. I think that we would suggest that the committee take a hard look at the ACO experiences. The ACO model, it may well be the ultimate value-based purchasing model. This model connects physicians -- it hits a lot of the goals that we talked about in our testimony. It connects the physician, fully informed with a full set of claims data, to the patient, and thinking about that patient broadly, outside the walls of the office, outside the 15-minute office visit, outside the writing of the prescription, but thinking about it much more broadly. We do like the idea of providers, whether they are acute-care hospitals or home-care agencies or anywhere in between, having a responsibility to a degree, to the degree that it is controllable, for what happens to that patient once they are discharged.

And we believe that our experiences in the ACO world, where our successful ACOs have increased their use of home health -- they have increased their use of hospice. They have driven down the total spend by using these kinds of care. And they have significantly increased the number of primary care interventions that are happening at that patient level. And so we would encourage the committee and staff to really take a hard look at those opportunities.

Mr. Kind. I couldn't agree with you more. I obviously hail from an area of the country, western Wisconsin, where I have gone to school on our providers there, whether it is the Mayo, or the Gundersen models, or Marshfield, the ThedaCare and that, that have been really establishing models of care so that it is more integrated and more coordinated, the patient center that you have been advocating as well. And we have been looking at some very good outcomes.

But in the post-acute care world now, you have different providers with different charges. How do we get all of them on the same page so that they are more accepting of a more integrated patient-centered delivery model that others have shown?

Mr. Guenthner. Well, this is one of the reasons that, as you know, we are in favor of the committee's work here and the need for the program to say to provider types, "This is what we want you to do," and then for providers to be held accountable to do those things.

And so, while there are imperfections in almost anything that we do, the need to move forward so outweighs the need to hold still, the need to do nothing. And so we have to continue to move forward to make progress, to try some new things, see if they work. And if they don't work, then we need to fix them. But we absolutely have to move forward.

Mr. Kind. I think moving forward with clear guidelines on what quality measures is the goal here, is going to be important too. I know there's been some kind things said about the IMPACT Act and the establishment of quality measures, data collection. I know some of that is years down the road, which, being the impatient guy that I am, frustrates me that we have to wait a few years before a lot of this starts coming in and that, but making sure that the quality measurements are clear, that the goals are clear, and then we start aligning the financial incentives in order to encourage providers to hit that is going to be one of the goals we have with the legislation that we have introduced that hopefully we can achieve again with all of your help. So thank you, again, for your testimony here today.

I yield back Mr. Chairman.

Chairman Tiberi. Mrs. Black is recognized for 5 minutes.

Mrs. Black. Thank you, Mr. Chairman.

And I want to follow up on Mr. Kind's questioning.

So I am hearing from some of the providers in my district that have concerns about the timing, the timing of when the IMPACT Act measures are coming online and when those measures can be ready for use in pay-for-performance programs.

So my understanding is that some of the IMPACT measures are ready now, such as the Medicare spending per beneficiary measure, but some of the IMPACT measures are not yet finalized, such as the functional status. My question is, do we need to wait until all of the measures are ready to begin the pay-for-performance program, or do you think that we can start a program with the measures that are ready now and then transition other measures in a later timeframe? I wanted to ensure that any future developments in this space work hand in hand with the objectives that can be achieved with the IMPACT Act.

So, Ms. Gage, if I could start with you and have you give me your thoughts on that.

Ms. Gage. Certainly. And just to broaden your thinking a little bit, in terms of timelines and readiness, the function measures have actually been endorsed by the National Quality Forum, and the standardized elements have been added to all of the assessments. And so those are actually quite ready.

And function is one of the greatest predictors of re-hospitalization and other complicating factors. So it is a very important metric. Similarly, the medical complexity is another important factor, and much of that is standardized. Some of the work on cognition, which is an important risk adjuster for some smaller portion of the population, is still being finalized, although there are some available elements. And the work that the MedPAC did this past year, based on my team's former work with the post-acute care payment reform demonstration, showed that the items that are important in terms of predicting resource intensity or predicting readmissions or predicting functional change are among those that have been tested, are reliable, and are being considered in the different assessment tools.

So I think you are ready to move forward. You don't have as much specificity in your model, perhaps, as once the rest of the measures are also ready, but you have some key critical factors. And when you put transition times around payment model implementations, it softens some of that first-end complications.

Mrs. Black. Ms. Wynn, do you have a thought on that?

Ms. Wynn. I am not as familiar with the measures or the status of the measures in the post-acute world.

Mrs. Black. Mr. Guenthner?

Mr. Guenthner. Yes. Thank you.

We think the functional measures are incredibly important to patients. And I am thrilled to hear Dr. Gage tell us that those are ready. I think that, as I said in response to Mr. Kind's question, if the choice is to hold still or move forward, we are a big fan of moving forward. Now, one of the ways to mitigate some of the exposure around potential missteps is to moderate the amount of financial risk for providers so that we don't -- if we miss, we don't -- excuse me -- overstate a miss by having too much at risk.

Mrs. Black. Doctor?

Dr. Worsowicz. I would agree with my colleague. If we are going to move forward, make sure that we have some flexibility on the risk models. And with all these programs, it is an evolution that we are going to evolve in time, move things forward, have flexibility within the program.

Mrs. Black. Thank you.

I yield back.

Chairman Tiberi. Thank you.

Mr. Lewis is recognized.

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

And I want to thank every member of the panel for being here, for your great and good testimony.

Ms. Wynn, in your testimony, you explain how some types of hospitals are doing better in performance-based programs. You stated that hospitals servicing low-income patients and those that focus on teaching do not do as well. Can you explain more about the trend that you are seeing, the weaknesses?

Ms. Wynn. Sure. I would point back to the conversation around the readmissions penalty program and our concerns there that the rates of readmission rates are not risk-adjusted for the patient's socioeconomic condition. So, in terms of safety net hospitals, that definitely confers or imposes additional penalties on them relative to other hospitals.

And then, for teaching hospitals, they also tend to treat large socioeconomically disadvantaged populations, so they have the same issues on the readmissions side, but they are also disproportionately hit by the hospital-acquired condition or complication penalty. Because these are rare events, what CMS does is they essentially put smaller hospitals that have very few of these events, they put them at the national average. And they say: These events are too rare for us to really calculate what your penalty should be, so we are going to assign you the national average.

In the complications penalty, it is only the bottom quartile of hospitals, so the bottom 25 percent, that is penalized, so that means that smaller hospitals that are assigned the national average will essentially never be penalized, right, because they can't work their way into the bottom quartile, and that leads to really the larger teaching hospitals and urban hospitals in the penalty bucket.

Mr. Lewis. Thank you very much for your response.

Thank you. I yield back.

Chairman Tiberi. Dr. Price is recognized for 5 minutes.

Mr. Price. Thanks so much, and I appreciate the chair's forbearance on schedule.

And I want to thank everybody for their testimony.

I want to highlight a couple of items. I was here earlier, as you all were providing that testimony, and I was struck by, Dr. Worsowicz, your apt description that patients are unique and that one -- it may have been you, Mr. Guenthner -- one patient with a diagnosis of stroke is not like another patient with a diagnosis of a stroke. Same diagnosis, different treatment in that the quality decisions that are made ought to be made by patients and families and doctors who are providing the care as opposed to somewhere else.

I want to, Mr. Guenthner, I want to talk about hopefully three specific, very clear items under the home-health arena. First, is the reclaim review that has been proposed. On May 25 of this year, 116 bipartisan Members of the House sent a letter to CMS urging that CMS rescind the proposal for the five-State demonstration project. At one point, a Medicare official recommended that home-health agencies fax in documents, as the electronic system was not working. Home-health providers are experiencing submission issues that require more than 45 minutes for each and every preclaim review request. Preclaims rejection rate is between 70 and 80 percent. So physicians and others have complained that home-health agencies and CMS regarding the intensive paperwork burden and confusion -- on and on and on.

The question is, would we be aided by a delay in this demonstration so that CMS can get their act together, and we can help assist them to refine this program?

Mr. Guenthner. Yes, sir, I believe we would. As I commented in my testimony, this PCR, or preclaim review, topic is a direct result of the physician face-to-face requirement that included a subjective narrative that the home-care industry, Almost Family included, commented to CMS was likely to result in very high audit error rates, because the auditor, 18 months or 2 years after the fact, would subjectively review the narrative written by the physician solely on the basis of the face-to-face document, not on the basis of the entire medical record.

Mr. Price. What could we do to remedy the face-to-face regulation?

Mr. Guenthner. So I think that CMS has rolled some of this back. CMS has changed some of the requirements. We would like to see it much more prescriptive. We would like to see it much easier for physicians to execute. And what we have here is a trust problem. When the physician certifies the need for home care, they have certified that they have seen the patient, the only reason to have them have to write a narrative that could be challenged later is because we don't trust the physician's certification.

Mr. Price. Just checking the box?

Mr. Guenthner. Yes, sir.

Mr. Price. I want to jump to the Medicare appeals backlog in home-health providers. In Georgia, there is a home-health provider with $92,000 denial on over 29 claims, five locations. These claims have slowed to a crawl. Many of them have been going on for 4, 5 years in spite of a 90-day requirement under the statute. So it seems that this backlog is only growing, and I wonder if you would agree with me that a global appeal settlement similar to the ones used for hospitals would provide some relief to the ALJ hearing backlog?

Mr. Guenthner. Yes, sir, emphatically so.

Mr. Price. Thank you.

And I just want to highlight one other item, and that is the value-based purchasing model and the withhold that was set up for hospitals. And the percent withhold for hospitals was 1 percent, growing to 2 percent over a 5- to 6-year period of time, as I recall. The proposal in the post-acute care space, as you know, is a 3-percent to an 8-percent back -- or withhold. When I speak to the folks trying to help patients back home and providing the care in the home-health arena, they tell me that in many cases their margin isn't 8 percent. And so I wonder if it would -- do you believe that it would be more appropriate, if they are going to go down this road, to have a withhold that is equivalent or the same as what the hospital community went through?

Mr. Guenthner. Yes, sir. We do think that parity is important across provider groupings and that the amount at risk should not get out in front of the infrastructure and the information available necessary for providers to execute.

If we get too much at risk, we have too high a risk of an adverse outcome or unanticipated event.

Mr. Price. Dr. Worsowicz, would you agree with that?

Dr. Worsowicz. Yes. I agree whatever you put at risk, we have to make sure we don't have an adverse outcome providing access to the patient.

Mr. Price. Thank you.

Chairman Tiberi. The gentleman's time has expired.

Mr. Crowley is recognized.

Mr. Crowley. I appreciate the chairman. Thank you very much for giving me the opportunity to be a part of the panel today. I want to make sure you make the vote as well as Dr. Price and that I make it as well.

I did want to stay particularly to congratulate you for the bipartisan approach in terms of the panel today and the discussion that has gone on here as well. I think it is unusually a rational and coherent hearing today.

Particularly, I want to welcome Ms. Wynn to the panel. As a New Yorker, how incredibly proud I am of the work of New York hospitals working under tremendously difficult situations at times, given the complex challenges, complexity of the cases that New York sees and treating a very challenging population in many respects but at the same time still training one out of every six doctors in the United States, I think it needs to be said and applauded as well.

I think you made reference to particular challenges that teaching hospitals have in this environs and especially low-income and safety net communities. I think the word we are looking for is flexibility, having that flexibility of recognizing those challenges and not penalizing for those challenges, but recognizing and understanding them and meeting those needs so that the needs of the patients are met, certainly the quality. We all want the best outcome. The problem is, though, when patients come to the hospital not in stage I or stage II, but stage III and IV, because they don't have insurance and can't have insurance, it cost more to treat, and the outcome will just not be as good as patients who get there at stage I and stage II, where it costs less to treat and the outcome tends to be better. So I think that is an important point to recognize from the mere perspective, I think, for large cities as well.

So I don't have any particular -- I have some questions. We will get them to the committee, maybe have you all answer them.

I just want to thank the chairman for this time.

Chairman Tiberi. Thank you, Mr. Crowley.

We have 2 minutes left to vote, so, unfortunately, we have to go.

I would like to thank the witnesses. You guys were awesome. I very much appreciate it. These are very important issues and look forward to engaging with you in the future.

Please be advised that members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the public record. Thank you.

With that, we are adjourned.

Ms. Wynn. Thank you.

[Whereupon, at 1:30 p.m., the subcommittee was adjourned.]

Public Submissions for the Record