THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE POST-ACUTE CARE PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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THE PRESIDENT'S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE POST-ACUTE CARE PAYMENTS

FRIDAY, JUNE 14, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 9:29 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Brady Announces Hearing on The President's and Other Bipartisan Proposals to Reform Medicare Post-Acute Care Payments

The House Committee on Ways and Means, Subcommittee on Health Chairman Kevin Brady (R–TX) today announced the fourth in a series of hearings to explore bipartisan proposals, including those contained in President Obama's Fiscal Year (FY) 2014 Budget to reform Medicare. This hearing will focus on review of proposals to reform post-acute care under the Medicare program. **The hearing will take place on Friday, June 14, 2013 in 1100 Longworth House Office Building, beginning at 9:30 A.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

In 2011, Medicare spending on Post-Acute Care (PAC), defined as Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), Inpatient Rehabilitation Facilities (IRF) and Long-Term Care Hospitals (LTCH) totaled nearly $62 billion. Medicare post-acute providers play an important role in the continuum of care for Medicare beneficiaries, providing recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. However, the lack of placement guidelines for beneficiaries in PAC settings, the uneven availability of PAC providers across markets, and multiple PAC payment systems result in wide variation in the use, cost and quality of post-hospitalization care for Medicare beneficiaries.

To address these and other concerns, the Obama Administration has identified several policies to reform PAC within the Medicare program. In the President's FY14 Budget, the Administration focused on five PAC reform policies: (1) reducing market basket updates for HHAs, SNFs, IRFs and LTCHs; (2) creating site neutral payments between IRFs and SNFs for certain procedures; (3) modifying the criteria required for IRF status (the so-called "75 percent rule"); (4) establishing a SNF readmissions program; and (5) creating PAC bundled payments.

The President's FY14 Budget estimates that these five policies will save $94 billion over 10 years. However, the Congressional Budget Office estimates these policies will save $53 billion. In addition to the President's budget, several other bipartisan policy organizations, such as the Bipartisan Policy Center, The Moment of Truth project and the Medicare Payment Advisory Commission, have collectively made recommendations to reform Medicare's PAC payment systems.

In announcing the hearing, Chairman Brady stated, **"The new Medicare Trustees report confirms this important program remains in deep financial trouble, with only 13 years left of solvency in the main trust fund. Democrats and Republicans recognize one solution to extending the life of Medicare is to improve how care is delivered to seniors once they leave the hospital. Finding the right reforms in post-acute care can both improve care for today's seniors and help save Medicare for the future generations."**

Ranking Member McDermott stated, **"The Affordable Care Act put us on a path towards reforming post-acute care and many promising ideas are being developed and tested. As the Medicare Trustees' Report illustrates, the Medicare program is stable and strong, however, we should always look for ways to continue to strengthen it and improve the quality of care**

for its beneficiaries. Improvements in post-acute care are a better approach for reform than policies that merely shift costs to beneficiaries."

FOCUS OF THE HEARING:

The hearing will review proposals to reform post-acute care under the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Friday, June 28, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BRADY. Good morning. The subcommittee will come to order.

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

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

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

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

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

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

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

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

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

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

Without objection, so ordered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I yield back the balance of my time.

Chairman BRADY. Thank you.

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

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

Mr. Blum, we will begin with you.

STATEMENT OF JONATHAN BLUM, ACTING PRINCIPAL DEPUTY ADMINSTRATOR AND DIRECTOR, CENTER FOR MEDICARE & MEDICAID SERVICES

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

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

Over the past several years, CMS has spent much time analyzing geographic differences in health spending and outcomes, particularly for the Medicare fee-for-service program. Our work com-

plements efforts performed by the Institute of Medicine, the Dartmouth Atlas, and MedPAC.

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

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

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

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

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

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

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

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

This year's President's budget also proposes some additional changes that we feel are very important to achieve the President's

goal of reducing Medicare spending by about $371 billion over the next 10 years without compromising the quality of the care the program provides.

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

I would be happy to answer your questions.

Chairman BRADY. Thank you, Mr. Blum.

[The prepared statement of Mr. Blum follows:]

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING ON FRIDAY JUNE 14, 2013 AT 9:30 AM

STATEMENT OF

JONATHAN BLUM

ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICARE,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

POST-ACUTE CARE IN THE MEDICARE PROGRAM

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH

JUNE 14, 2013

Statement of Jonathan Blum on
Post-Acute Care in the Medicare Program
House Committee on Ways and Means, Subcommittee on Health
June 14, 2013

Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for this opportunity to discuss spending on post-acute care in the Medicare program, and to highlight the efforts of the Centers for Medicare & Medicaid Services (CMS) to reform payments for post-acute care. Spending on post-acute care services is the greatest source of geographic variation in the Medicare fee-for-service program, but greater spending on these services does not appear to be associated with better health care outcomes. As a result, CMS is aggressively working to better manage Medicare's spending on post-acute care through a series of payment changes, and is conducting ongoing work to develop new payment and delivery system models like Accountable Care Organizations and bundled payments. In addition, the President's FY 2014 Budget includes several important proposals to promote efficiency and improved quality in the post-acute settings. Any effort to reduce overall Medicare spending while improving quality of care must carefully consider Medicare's current policies for post-acute care benefits, and I look forward to working with the Subcommittee on these issues over the coming year.

Post-Acute Care Spending

Post-acute care is the skilled nursing care and therapy typically furnished after an inpatient hospital stay. It is provided in a variety of settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and in patients' homes by home health agencies (HHAs). Often provided with the goal of shortening a patient's hospital stay, post-acute care is just one component of a broad care delivery continuum. Unfortunately, care across that continuum can be fragmented, as patients may pass through the care of multiple providers, and the providers may not consistently and accurately communicate information on the course of treatment with all those involved in the patient's care. Additionally, providers face financial incentives that are not always well-aligned with the cost and the quality of patient care. Health care often is not delivered in the most efficient, clinically appropriate, and cost-effective care setting. Post-acute care, in particular, is often delivered in more intensive care settings where Medicare payments are higher, when effective and appropriate care can be

delivered in a lower-intensity setting. Better management of post-acute care will be a key component to any successful effort to reform and improve the Medicare program.

Furthermore, Medicare spending per beneficiary varies widely throughout the country,[1] and geographic variation in spending is particularly high for post-acute care. In 2011, the Medicare Payment Advisory Commission (MedPAC) examined Medicare FFS regional spending variation in three composite sectors: acute inpatient, which included short-term inpatient and psychiatric care; ambulatory, which included physicians, ambulatory surgical centers, and labs within hospital outpatient facilities; and post-acute, which combined HHAs, SNFs, LTCHs, and IRFs. MedPAC's analysis found that the post-acute care sector showed the greatest variation, with spending of $60 per member per month in the lowest-use area to almost $450 in the highest-use area.[2] In 2013, the Institute of Medicine's Committee on Geographic Variation analyzed Medicare post-acute care spending in 2007 through 2009 by SNFs, HHAs, hospices, LTCHs, and IRFs to determine the extent to which variation in post-acute care spending contributes to variation in total, all-cause Medicare spending. The Committee found that 40 percent of all variation in Medicare spending is explained by variation in the utilization of post-acute care services.[3]

Spending patterns across the country for post-acute care following discharge for two different diagnosis-related groups (DRGs) show the extent to which Medicare spending on post-acute care varies by region. For example, for major joint replacement or reattachment of lower extremity without multiple chronic conditions (MS-DRG 470), per capita spending on post-acute care averages $7,114 nationally, including spending at SNFs, IRFs, LTCHs, and by HHAs. However, post-acute care spending for joint replacement, the same MS-DRG-470, across the country varies widely. For an episode of care in Charleston, West Virginia, average spending totals $4,887 per

[1] Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence.* Retrieved (December 2011) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.
[2] MedPAC (January 2011). *Regional Variation in Medicare Service Use.* pp 6-7. Retrieved (May 24, 2013) at http://www.medpac.gov/documents/Jan11_RegionalVariation_report.pdf
[3] Institute of Medicine (2013) *Interim Report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: Preliminary Committee Observations*. Retrieved (June 3, 2013) at http://www.iom.edu/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx

capita, 30 percent less than the national average. In Hackensack, New Jersey, average spending per episode of care totals $12,862 per capita, or nearly double the national average.[4]

Medicare spending on post-acute care can even vary widely within one state. For intracranial hemorrhage or cerebral infarction with chronic conditions (MS-DRG 65), the national average for Medicare post-acute spending on an episode of care is $12,660. For this episode of care in Temple, Texas, per capita spending totals $5,818, less than half the national average. In Wichita Falls, Texas, however, spending for this type of episode of care totals $18,202 per capita, nearly 150 percent of national average spending.[5] These variations in post-acute Medicare spending are costly for taxpayers and threaten the sustainability of the Medicare trust fund.

In addition to differences in utilization of certain services and in other variables, payment vulnerabilities also contribute to the high degree of variation in post-acute care spending across the country. CMS' program integrity efforts have identified improper billing schemes by post-acute care providers including SNFs billing for services not provided or not medically appropriate; SNFs billing for individual therapy when group therapy was provided; IRFs billing for services rendered without physician orders; HHAs billing for care for beneficiaries who are not homebound; and HHAs purposefully delaying discharge of patients when skilled care is no longer needed. Some of these improper billing practices point to potential overtreatment of Medicare beneficiaries, with patients receiving more intensive care than is medically warranted. They also point to the importance of both anti-fraud efforts as well as improvements in the way CMS pays for post-acute care to incentivize high-quality care delivered in the most appropriate care setting.

CMS' Progress in Addressing Post-Acute Care Spending

To address these longstanding challenges in post-acute care spending, CMS is taking concrete steps to encourage payment accuracy and higher value in post-acute care. Two primary modes of action are direct payment changes through rulemaking, and testing new payment and service

[4] Calculations based on internal analysis using data from the CMS Chronic Condition Warehouse, available at http://www.ccwdata.org/web/guest/home

[5] Calculations based on internal analysis using data from the CMS Chronic Condition Warehouse, available at http://www.ccwdata.org/web/guest/home

delivery models through the Center for Medicare and Medicaid Innovation (CMS Innovation Center).

Direct Post-Acute Care Payment Changes

CMS is aggressively working to better manage Medicare's spending on post-acute care through a series of payment changes. CMS has already made several direct changes to better align post-acute care payments with costs and address payment vulnerabilities, and is continuing to do so through proposed rules on FY 2014 payment rates.

SNF Resource Utilization Group System Refinements

SNF residents are classified into distinct groups based on the relative resource intensity that would typically be associated with each resident's clinical condition, as identified through a resident assessment. The classification groups, referred to as Resource Utilization Groups (RUGs), are used to establish the SNF prospective payment system (PPS) payment. CMS has taken steps to refine the RUGs through the years to pay appropriately for the types of patients using SNF services. The most recent RUG refinement was in FY 2011 when the SNF PPS transitioned from the previous, 53-group refined version 3 of the Resource Utilization Groups (RUG-53) to the new 66-group version 4 (RUG-IV) classification system. The transition from RUG-53 to RUG-IV was intended to be budget-neutral, ensuring that the transition itself would not result in any change in overall Medicare expenditures under the SNF PPS. However, CMS noticed significant changes in SNF provider behavior immediately upon implementation of the new version of the RUGs. Since the SNF PPS rates had been set assuming therapy utilization would decrease under the new RUG system, the rates for FY 2011 were set too high and, rather than maintaining budget neutrality in the transition as intended, actual Medicare expenditures for SNFs during FY 2011 exceeded projected expenditures by $4.47 billion.

In response to this unintended spike in payments, in FY 2012, CMS recalibrated certain case-mix indexes used to determine the per diem rates to restore overall payments to their intended levels on a prospective basis, which equated to a reduction in SNF expenditures of $4.47 billion. In addition, we developed and implemented an active ongoing monitoring program to ensure that the various policy interventions had their intended effect, as well as identify any other changes in

provider behavior. This monitoring shows that beneficiary access has remained stable throughout these interventions.

SNF Therapy Payment Research

Since 1998, Medicare has paid for services provided by SNFs under the Medicare Part A benefit on a per diem basis through the SNF PPS. Currently, the therapy payment rate component of the SNF PPS is based solely on the amount of therapy provided to a patient, regardless of the specific patient characteristics. CMS has contracted with Acumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF PPS. As an initial step, the project will review past research studies and policy issues related to SNF PPS therapy payment and options for improving or replacing the current system of paying for SNF therapy services.

Home Health Therapy Clarifications

CMS has also made post-acute care payment changes in response to data analysis and recommendations from MedPAC. Analysis of 2008 home health data suggested that some HHAs may have been providing unnecessary therapy, and in its March 2010 report, MedPAC suggested this data also revealed a 26 percent increase in episodes with 14 or more therapy visits. These analyses suggested that therapy payment policies were vulnerable to fraud and abuse. They also suggested another fundamental concern—that payment incentives had a significant effect on treatment patterns because the eligibility criteria for the home health benefit were ill-defined.

CMS acted quickly in response to MedPAC's analysis. In calendar year (CY) 2011 rulemaking, we clarified our coverage of therapy services policies to curb misuse of the benefit. Specifically, we required that HHA providers describe measureable treatment goals in a patient's plan of care and measure progress toward achieving those care goals to determine the therapy's effectiveness. To address the delivery of unnecessary therapy services under the HHA prospective payment system, we required that a qualified therapist (instead of an assistant) perform the needed therapy services and assess the patient, measure progress, and document progress toward goals at least once every 30 days during a therapy patient's course of treatment. In addition, for those patients needing 13 or 19 therapy visits, we required a qualified therapist to perform the therapy service

required at the 13th and 19th visit, assess the patient, and measure and document effectiveness of the therapy. Except in cases where the patient meets the criteria for needing maintenance therapy, Medicare would cease coverage of therapy services if progress toward plan of care goals could not be measured or expected in a reasonable and predictable timeframe.

Rebasing the Home Health Payment System

The Affordable Care Act required rebasing the Home Health PPS to reflect such factors as changes in an episode regarding the number of visits, mix and level of intensity of services, the average cost of providing care, and other relevant factors. The rebasing is required to be phased-in in four-year increments with the adjustments fully implemented for 2017. CMS will be proposing these adjustments in this year's rulemaking for CY 2014.

Home Health and Program Integrity

The Affordable Care Act mandated that for a patient to be eligible for the home health benefit, the certifying physician must document that they, or a permitted non-physician practitioner (NPP), had a face-to-face encounter with the patient. In our CY 2011 Final Rule, we finalized a policy to allow the face-to-face encounter to occur up to 90 days prior to the start of care, and up to 30 days after the start of care. In our CY 2012 Final Rule, we allow the patient's acute or post-acute physician to fulfill the requirement of informing the certifying physician of their encounters with the patient to satisfy the face-to-face encounter requirement. These policies ensure flexibility in certifying a patient's eligibility for home health care while ensuring that patients who receive the benefit have a bona fide need.

There are additional Affordable Care Act established safeguards currently in place. For instance, CMS designates newly enrolling HHAs as high risk, flagged for screening and potential administrative actions, including licensure checks, as well as unannounced site visits, and an FBI criminal history record check upon completion of CMS's enrollment process.

LTCH Chronically-Ill and Medically-Complex Criteria

The FY 2014 proposed rule for LTCHs includes research findings on criteria to better identify chronically critically ill and medically complex patients. Typically, these patients are treated in

acute care hospitals and LTCHs, but their predictable and consistent need for extended hospital-level care may be better met through stays in step-down units of inpatient prospective payment system hospitals, or in LTCHs. The proposed rule solicits feedback on the research about this patient population with an eye toward formulating new policy proposals for FY 2015.

Hospice Payment Reform

The Affordable Care Act requires revisions to the methodology for determining hospice payment rates no earlier than October 1, 2013. CMS has been conducting analyses and has solicited stakeholder input on hospice payment reform. The FY 2014 Hospice Wage Index and Payment Rate Update proposed rule provides an update on the hospice payment reform efforts. This update includes data collection efforts, initial findings on rebasing the routine home care rate, and discussion of various payment reform model options, including one recommended by MedPAC in its March 2009 Report to Congress.

Proposed SNF, IRF, LTCH, and Hospice Payment Changes for FY 2014

CMS is also taking active steps to address post-acute care spending through FY 2014 payment rate proposed rules. In April and May 2013, Medicare released proposed rules that would change the way post-acute care is valued and reported and the way post-acute care payments are forecast.

The FY 2014 SNF PPS proposed rule recommends changes in SNF reporting and payment. To ensure accurate case-mix assignment and payment, the proposed rule would add an item to the SNF resident assessment instrument, the Minimum Data Set (MDS) 3.0, which would require providers to record the number of distinct calendar days of therapy provided across all rehabilitation disciplines. Currently, the number of therapy days for each individual therapy discipline reported on the MDS 3.0 is simply summed, resulting in higher SNF payments than are warranted for some patients. The proposed rule would also revise and rebase the SNF market basket, basing it on data from FY 2010. Currently, the market basket index is based on FY 2004 data. The SNF proposed rule would also make a change to the way in which CMS reports the SNF market basket forecast error in certain instances, which would allow CMS to more accurately report the difference between the actual and projected market basket percentage

change in these instances for a given year, and to more accurately determine whether a forecast error correction is warranted.

Also included in Medicare's FY 2014 payment rate rules are proposed changes to update IRF PPS rates. To improve the accuracy of IRF facility-level payment adjustments, the IRF proposed rule would add a new variable in the adjustment methodology to account for whether the IRF is a freestanding hospital or a unit of an acute care or critical access hospital. CMS is also proposing changes in the way inpatient hospitals qualify for higher IRF rates rather than lower hospital inpatient rates. Currently, an inpatient hospital must demonstrate that at least 60 percent of its patients meet criteria including the need for intensive inpatient rehabilitation services for one or more of 13 listed conditions. Compliance is demonstrated through either medical review, or by comparing the patient's diagnosis codes with a list of codes indicating "presumptive compliance." Proposed rules would revise the diagnosis codes on the "presumptive compliance" list so that they better indicate, without the need for further medical review, both the presence of one of the 13 approved conditions *and* the patient's need for intensive rehabilitation.

CMS is also proposing changes to LTCH payment. Under the proposed rules, a LTCH that admits more than 25 percent of its patients from a single acute care hospital would be paid at a rate comparable to inpatient prospective payment system hospitals for those patients above the 25-percent threshold. A statutory moratorium on the enforcement of this policy was in place from December 2007 to December 2012. In FY 2013 rulemaking, CMS extended the moratorium through September 30, 2013, while we continued to research the types of criteria that best identify patients who are appropriately treated in LTCHs.

Medicare's FY 2014 payment rate rules also reflect CMS' ongoing efforts to support beneficiary access to hospice. To gain a better understanding of those who are served by the Medicare hospice program, the rules clarify appropriate diagnosis coding in hospice claims. We propose requiring providers to code the principal diagnosis using the underlying condition that is the main focus of the patient's care, and would not allow for the inappropriate use of non-specific diagnosis codes or codes that are not for the patient's principal diagnosis.

Quality Reporting and Value-Based Purchasing Programs

The Affordable Care Act required CMS to establish in Medicare quality measures and quality reporting programs for IRFs, hospices and LTCHs, with payment adjustments for providers that do not report specified quality data to the Secretary beginning in FY 2014. Tying payment to quality reporting has moved the Medicare program toward rewarding better value, outcomes, and innovations instead of the volume of services provided. The proposed FY 2014 payment rate rules for IRFs, hospices, and LTCHs propose to adopt updated quality measures and changes to quality reporting requirements. These proposals for post-acute care quality reporting, if finalized, will help CMS monitor and assess beneficiary access to high-quality care. In addition, the Affordable Care Act required the Secretary to develop plans for implementing value-based purchasing (VBP) programs for SNFs and home health agencies, and HHS submitted reports to Congress in 2012. VBP has been implemented successfully for the inpatient acute care hospital setting, and creating VBP programs for post-acute care settings would enhance CMS' efforts to improve quality of care.

Delivery System Reforms

In addition to this aggressive management of payment policies, CMS is working to develop and test new delivery system models that will further impact the way post-acute care is delivered. The Affordable Care Act provided CMS with valuable tools to help us research and demonstrate care improvements and lower costs by creating the CMS Innovation Center. The CMS Innovation Center is focused on testing new payment and service delivery models, evaluating results and advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing. Several of the CMS Innovation Center's initiatives test payment and delivery models that include or are specific to post-acute care.

Bundled Payments

CMS recently launched the Bundled Payments for Care Improvement initiative, a new payment model developed by the CMS Innovation Center. Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care and a lack of coordination across health care settings. Research has shown that bundled payments can align

incentives for providers– hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.[6]

The Bundled Payments for Care Improvement initiative is composed of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Two of the four models include payments for post-acute care. Model 2 makes retrospective bundled payments for acute care hospital stays plus post-acute care. Retrospective payment means that the providers and practitioners are paid as usual until a later reconciliation determines their performance against a target amount. Model 3 also makes retrospective bundled payments, but only for post-acute. For both of these models, an episode of care ends either 30, 60, or 90 days after hospital discharge or post-acute care initiation, respectively, and participants are able to select up to 48 different clinical condition episodes.

CMS is implementing Models 2 and 3 in two phases. CMS is working with participants in the models during an initial period (Phase 1) to prepare for financial and performance accountability for episodes of care prior to the participants potentially being selected by CMS as awardees and entering the "risk-bearing" period of performance (Phase 2). Currently, 55 organizations representing 193 health care facilities are participating in Phase 1 of Model 2. Fourteen organizations representing 166 health care facilities are participating in Phase 1 of Model 3. The "risk-bearing implementation" period, Phase 2, is expected to begin in October 2013. Those participants in Phase 1 of Models 2 and 3 that are ultimately approved by CMS and decide to move forward with assumption of financial risk may enter into an agreement with CMS and begin Phase 2 of the Model. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare. The CMS Innovation Center will collect and monitor quality measures to maximize the ability to detect successes, protect patients, better serve populations,

[6] Cromwell J., Dayhoff DA., McCall NT, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.
Abt Associates, Inc., Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report, Cambridge, Mass: Abt Associates, Inc; 1997.
Casale A.S. et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care, Annals of Surgery. 2007;(246) 4:613-621.
Medicare Acute Care Episode Demonstration.
http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf.

and generate useful information to support care design. The initiative is using the Continuity Assessment and Record Evaluation (CARE) Tool to better understand and monitor the beneficiary's experience of care and outcomes of care. The CARE tool was designed to collect standardized patient clinical and functional information not otherwise available from claims. Finally, the initiative will facilitate opportunities for participants to share their experiences with one another and with participants in other CMS Innovation Center initiatives. Learning networks among awardees will allow awardees to learn best practices from their peers and to further develop their initiatives throughout the agreement period.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one of the Affordable Care Act's key reforms to improve the delivery of care. ACOs are groups of doctors and other health care providers that have agreed to work together to treat individual patients and better coordinate their care across care settings. They share—with Medicare—any savings generated from lowering the growth in health care costs while improving quality of care including providing patient-centered care. Because savings may only occur if acute and post-acute and other care providers work together, ACOs help encourage well-coordinated care across the care continuum.

In just over a year, over 250 ACOs have been formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide. This is approximately eight percent of all beneficiaries in the Medicare program, and will grow over time as existing ACOs choose to add providers and more organizations are approved for participation in the program. They are located in 47 states and territories—from the most remote community in Montana to Puerto Rico.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities.

The Shared Savings Program requires that participants —which can be providers, hospitals, suppliers, and others— coordinate care for all services provided under Medicare FFS and encourages investment in infrastructure and redesigned care processes. ACOs that lower their growth in health care costs, while also meeting clearly defined performance standards on health care quality, are eligible to keep a portion of the savings they generate for the program. As a result of these efforts we are seeing providers developing strategies to work together to redesign care processes, promote preventive care, and better coordinate services for patients with chronic disease and high risk individuals.

In addition to the ACOs participating in the Shared Savings Program, the CMS Innovation Center is testing a different payment model for ACOs, the Pioneer ACO model. The Pioneer ACO model is designed for health care organizations that have experience coordinating care for patients across care settings. This model tests alternative payment models that include escalating levels of financial accountability. One purpose of the Pioneer ACO model is to inform future changes to the Shared Savings Program. Thirty-two organizations are participating in the testing of the Pioneer ACO model.

The Innovation Center is also testing the Advance Payment ACO model. The Advance Payment ACO model examines whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program from entities such as physician-owned and rural providers with less capital. Through the Advance Payment ACO Model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. It is our hope that the assistance the Advanced Payment Model provides to smaller and rural practices will result in expanding access to this coordinated care effort to more fee-for-service Medicare beneficiaries. Currently 35 ACOs are participating in this model.

Health Care Innovation Awards

The CMS Innovation Center is also testing new ways to efficiently deliver care and lower costs through its Health Care Innovation Awards. Round One of these three-year awards focused on engaging a broad set of innovation partners to test new care delivery and payment models;

identify new models of workforce development and deployment; and support innovators who can rapidly deploy care improvement models through new ventures or expansion of existing efforts to new patient populations. Grants ranging from $1 million to $30 million were announced in May and June, 2012, to 107 total participants. For example, the University of North Texas Health Science Center, in partnership with Brookdale Senior Living (BSL), received a Health Care Innovation Award to help identify, assess, and manage clinical conditions to reduce preventable hospital admissions and readmissions for residents living in independent living, assisted living and dementia specific facilities. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults. Building on the success of its first round, on May 15, 2013, the CMS Innovation Center announced Round Two of the Health Care Innovation Awards. In Round Two, the CMS Innovation Center is seeking proposals in four categories: models that are designed to rapidly reduce Medicare, Medicaid, and CHIP costs in outpatient and post-acute settings; models that improve the health of populations, defined geographically or by socioeconomic class; models that test approaches for specific types of providers to transform their financial and clinical models; and models that improve care for populations with specialized needs.

Independence at Home Demonstration

The Independence at Home Demonstration, created by the Affordable Care Act and conducted by the CMS Innovation Center, is testing a service delivery and payment incentive model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. The home-based primary care teams are directed by physicians and nurse practitioners. The Demonstration will award incentive payments to healthcare providers who succeed in reducing Medicare expenditures and meet designated quality measures. The Innovation Center selected a total of 18 individual practices and consortia to participate in the Independence at Home Demonstration.

Post-Acute Care Proposals in the President's FY 2014 Budget

The President's FY 2014 Budget contains many proposals to improve provider payments and encourage appropriate use of post-acute care in order to reduce Medicare costs while protecting

beneficiary access. These proposals would align payments with the cost of care, strengthen provider incentives to promote high-quality care, and encourage beneficiaries to seek high-value care. Together, these proposals would save $94.6 billion over ten years.[7]

Adjust Payment Updates for Certain Post-Acute Providers

MedPAC analysis shows that Medicare payment significantly exceeds the costs of care in post-acute settings, while also finding historically high Medicare profit margins for post-acute care providers. In 2011, IRFs had a 9.6 percent Medicare margin, and the aggregate LTCH Medicare margin was 6.9 percent. Aggregate Medicare profit margins for SNFs have been above 10 percent for 11 years since 2000, and MedPAC has found that the variation in Medicare margins is not related to differences in patient characteristics. In 2011, HHA Medicare profit margins in aggregate were 14.8 percent for freestanding agencies, averaging 17.7 percent from 2001 through 2010.

This proposal would gradually realign payments with costs through adjustments to payment rate updates. It would gradually reduce market basket updates for IRFs, SNFs, LTCHs, and HHAs by 1.1 percent in each year in 2014 through 2023. Payment updates for post-acute care providers would not drop below zero under this proposal.

Encourage Appropriate Use of IRFs

IRFs receive higher payment rates than other medical facilities, including SNFs which often provide care similar to that provided by IRFs for those IRF patients that are not part of the "60 percent rule." As such, we believe that facilities that are paid as IRFs should predominantly provide services to patients requiring more intensive care than can be provided at other medical facilities. Under current law, the classification criteria for IRFs require that at least 60 percent of an IRF's patients need intensive rehabilitation services for treatment of one or more of 13 specified conditions. After an initial phase in period, this classification requirement was originally set to peak at 75 percent, but was later reduced to no more than 60 percent by the Medicare, Medicaid, and SCHIP Extension Act of 2007. If adopted, the proposal would return

[7] Department of Health and Human Services (2013) *FY 2014 Budget in Brief*. p. 54, Retrieved (May 28, 2013) at http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf

the classification standard maximum to 75 percent to ensure that Medicare-paid IRFs are even more focused on treating patients who require specialized, intensive care that would justify the higher payments to IRFs.

Equalize Payments for Certain Conditions Treated in IRFs and SNFs

Currently, treatment of certain knee, hip and pulmonary conditions that do not require intensive therapeutic post-acute care can be performed in either an IRF or an SNF, but Medicare payments are much higher if the treatment occurs in an IRF. This proposal would encourage care delivery in the most clinically appropriate and cost-effective setting. It would, beginning in 2014, make Medicare payments more equal for certain knee, hip, and pulmonary conditions, as well as other conditions selected by the Secretary. These conditions are commonly treated at both IRFs and SNFs.

Adjust SNF Payments to Reduce Hosptial Readmissions

The Affordable Care Act required payment adjustments for inpatient hospitals with high rates of readmissions, many of which could be avoided through better care. This proposal would create a comparable program for SNFs, which have a crucial role in preventing unnecessary hospital readmissions. MedPAC analysis shows that nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. This proposal would align incentives for better care in skilled nursing facilities by reducing payments in facilities with high rates of hospital readmissions. Beginning in FY 2017, this proposal would reduce payments by up to three percent for SNFs with high rates of care-sensitive preventable hospital readmissions.

Implement Bundled Payment for Post-Acute Care Providers

Bundling episode of care payments can incentivize care coordination and appropriate and accurate payment. This proposal would implement bundled payment for post-acute care providers, including LTCHs, IRFs, SNFs, and home health providers, beginning in 2018. Payments would be bundled for at least half of the total payments made to post-acute care providers. The Secretary would specify the payment rate for an episode of care based on patient characteristics and other factors. The Secretary will have authority to adjust payments based on

quality of care, geographic differences in labor and other costs, and other factors as deemed appropriate.

Bundled payment rates would produce a 2.85 percent cumulative reduction in total payments to post-acute care providers by 2020. Beneficiary coinsurance levels would remain the same as those under current law (for instance to the extent the beneficiary uses SNF services, they would be responsible for the current law copayment rate).

Introduce Home Health Copayments for New Beneficiaries

Home health services represent one of the few areas in Medicare that do not currently include some beneficiary cost-sharing. This proposal aims to encourage appropriate use of home health services while protecting beneficiary access. It would create a co-payment for new beneficiaries of $100 per home health episode, starting in 2017. Consistent with MedPAC recommendations, this co-payment would apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay.

Conclusion

Post-acute care spending growth and geographic variation make controlling post-acute spending a key task for CMS. Better management and better alignment of payment with costs and attention to incentives will be key parts of successful Medicare reform. Using new tools provided in the Affordable Care Act, CMS is taking a holistic approach to post-acute spending through bundled payments and ACOs, both of which emphasize post-acute care as one aspect of a broader care continuum. At the same time, CMS is taking some more targeted actions, including rulemaking that change post-acute care payment systems to more accurately record and value post-acute care. The President's FY 2014 Budget takes these reforms a step further, proposing changes that would incentivize care delivery in the most efficient care setting, reduced readmissions, and better coordination of care. While these initiatives and proposals represent important first steps, more work remains to be done to make Medicare spending on post-acute care sustainable for the long term and improve the overall delivery of care. We look forward to working with the Subcommittee to continue to ensure access to high quality health care for all Medicare beneficiaries.

Chairman BRADY. Mr. Miller, you are recognized.

STATEMENT OF MARK E. MILLER, PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chairman BRADY. Thank you, Mr. Miller.

[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING ON FRIDAY JUNE 14, 2013 AT 9:30 AM

Medicare post-acute care reforms

June 14, 2013

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

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Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's work on post-acute care in Medicare.

MedPAC is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

The Commission has done extensive work on issues related to post-acute care (PAC); the way Medicare pays for these services; and the reforms that are needed to encourage a more seamless, patient-centered approach to match services and settings to the needs of each patient. We have considered reforms that would promote care coordination (such as bundled payments, accountable care organizations, and readmission policies), equalize payments made for similar services, and gather comparable data across PAC settings. Some changes, such as changes to fee-for-service (FFS) payments or the adoption of cross-sector quality measures, could be implemented relatively quickly. Payment reforms that cut across settings and fundamentally alter the way we pay for PAC will require continued hard work to design and implement.

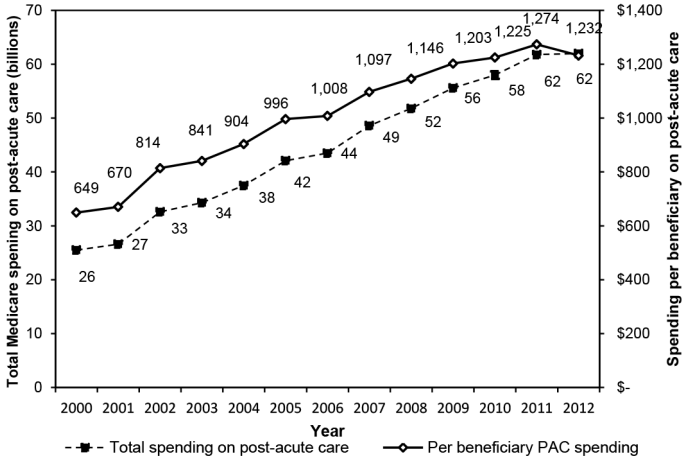
Background

PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries. In 2011, about 43 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting. Of those, almost half went to SNFs, 39 percent received home health care, and the remainder went to other settings, including IRFs and LTCHs. While all or almost all beneficiaries admitted to IRFs, SNFs, and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the

community. The characteristics of these community admissions suggest these users have long-term care needs. Beneficiaries can also receive outpatient therapy after a hospital stay. Though rarely the first site of care for conditions that typically use PAC, beneficiaries may receive outpatient therapy after using PAC.

In 2012, PAC FFS spending totaled $62 billion and accounted for 17 percent of FFS spending. PAC spending has more than doubled since 2000 (Figure 1). During this period, spending on a per capita basis rose 90 percent.

Figure 1. Large growth in Medicare's total and per capita spending on post-acute care since 2000

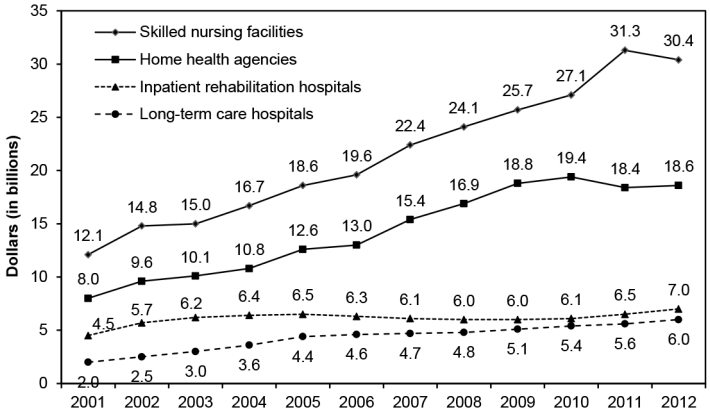


Note: PAC (post-acute care). These numbers are program spending only and do not include beneficiary cost sharing.
Source: CMS Office of the Actuary.

The Commission has documented changes in the numbers of providers, the mix of services they furnish, and the patients they treat (Figure 2). The explosive growth in the number of HHAs, the increase in the number of beneficiaries receiving home health care, and the

amount of care beneficiaries receive explain the more than doubling of Medicare's spending on home health care services. The intensification of rehabilitation services furnished by SNFs drove the two-and-a-half-fold increase in spending on these services. Medicare payments to IRFs and LTCHs grew rapidly after the adoption of the PPSs until other policies were put in place to control the types of patients treated in these high-cost settings. An almost 60 percent increase in the number of LTCHs during this period contributed to Medicare's increased spending in this sector.

Figure 2. Medicare's spending on post-acute care has more than doubled since 2001



Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

Challenges that undermine PAC reforms

Over many years, the Commission has discussed and made multiple recommendations regarding current Medicare's FFS payments and quality measures for PAC and the need for a more coordinated and integrated approach to PAC. Broad reforms to the way Medicare pays for PAC would encourage beneficiaries to go to settings that can provide the best outcomes for the lowest cost. Unfortunately, the FFS and PAC landscapes present many challenges to such reforms.

First, PAC is not well defined and the need for PAC services is not always clear. Some patients can go home from an acute hospital stay without PAC, while others need it but receive services in varying amounts and in different settings. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting. Medicare's rules and clinical evidence do not clearly delineate the types of patients who belong in each setting and the amount of service needed. The use of outpatient therapy is similarly vexed by the lack of guidelines about when and how much therapy is appropriate for a given condition.

Another complication is that while different PAC settings can furnish similar services, Medicare pays them different rates depending on the setting. For example, patients recovering from the lowest severity strokes are treated in IRFs, SNFs, LTCHs, and with home health care. Furthermore, Medicare's payment incentives can influence providers' decisions about which beneficiaries to admit and the care they furnish. For example, the home health care and SNF PPSs favor rehabilitation care over medically complex care because therapy payments are based on the amount of service furnished, and the increases in payments outpace the increases in the costs. Providers can increase their payments by delivering more services. As a result, the variation in PAC service use per beneficiary is larger than for other services. PAC service use varies two-fold between low-use and high-use geographic areas, while inpatient hospital service use varies twenty percent (Table 1). At the extremes, the differences are even larger: PAC spending varies eight-fold, while inpatient hospital services vary 60 percent.

Table 1. Comparison of service use variation across geographic areas

Ratio of high to low service-use areas	Inpatient hospital	Ambulatory care	Post-acute care
Areas at the 90th to 10th percentiles	1.22	1.24	2.01
Highest use to lowest use area	1.59	2.01	7.97

Note: Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties. Service use is measured as risk-adjusted per capita spending (adjusted for wages and special add-on payments) by sector among fee-for-service beneficiaries in each area.

Source: MedPAC analysis of 2006–2008 beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims.

Even among beneficiaries who used PAC and had similar care needs, Medicare spending on PAC varies more than three-fold (Table 2). These spending differences reflect the mix of post-acute care services (e.g., whether the beneficiary went to a SNF or an IRF) and amount of PAC used (e.g., the number of SNF days or home health care episodes).

Table 2. Medicare spending on post-acute care varies more than three-fold for conditions that often use these services

Condition	Spending on post-acute care within 30 days of hospital discharge			Ratio of 75th to 25th percentiles
	Mean	25th percentile	75th percentile	
Coronary bypass w cardiac catheterization	$5,286	$1,864	$6,913	3.7
Major small & large bowel procedures	$6,100	$2,110	$8,804	4.2
Major joint replacement	$8,152	$3,890	$11,484	3.0
Stroke	$13,914	$5,936	$19,371	3.3
Simple pneumonia & pleurisy	$7,039	$2,351	$10,785	4.6
Heart failure & shock	$5,997	$2,034	$9,331	4.6
Fractures of hip & pelvis	$11,688	$8,213	$14,427	1.8
Kidney & urinary tract infections	$8,040	$3,335	$11,963	3.6
Hip & knee procedures except major joint replacement	$13,608	$10,526	$16,498	1.6
Septicemia or severe sepsis w/o MV 96+ hours	$8,282	$3,344	$11,744	3.5
	Average of 10 conditions			3.2

Note: Post-acute care includes services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities). Spending is for care furnished within 30 days after discharge from an inpatient hospital stay.

Source: Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC.

Current use patterns do not necessarily reflect how much care patients should receive or where they would best receive their care because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect many factors, including the availability of PAC settings in the local market, the geographic proximity to PAC providers, patient and family preferences, or financial relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system or those it contracts with). PAC providers also have no incentive to consider the cost to Medicare of a patient's total episode of care or

to coordinate care across settings. As a result, providers focus on their silo of care, which may not best serve the beneficiary and potentially generates unnecessary costs to the program and beneficiaries.

Given the wide variation in service use, it is critical that Medicare and its beneficiaries compare the efficacy of services provided in different settings. However, currently PAC settings do not use a common patient assessment instrument, so the patients they treat and the outcomes they achieve cannot be easily compared. Medicare requires providers in the three settings (IRFs, HHAs, and SNFs) to use a tool specific to each setting and does not require LTCHs to assess patients using a uniform tool. Even for patient assessment data that are available, the measures, definitions, and scales differ.

Need to maintain accurate Medicare fee-for-service payments

Though not the end-point of payment reforms, Medicare must continue to ensure that FFS payment methods create appropriate incentives for providers, and the resulting payments are adequate and accurate. Three quick examples illustrate the responsiveness of the PAC industry to the PPSs' incentives and prices. First, the episode-based payment for HHAs created incentives to lower the number of visits per episode, and the average number declined 32 percent following the implementation of the PPS. Second, the SNF PPS and HHA PPS favor therapy services (over treatments required by medically complex patients), resulting in increases in the amount of therapy furnished and a shift to treating patients who require therapy services and away from treating medically complex patients. Last, the LTCH PPS pays much lower amounts for exceptionally short stays, so average lengths of stay now cluster just above the day thresholds to maximize payment with the minimum amount of services. Clearly, Medicare must concurrently refine its FFS policies while exerting pressure on providers to control their costs and be receptive to new payment methods and delivery reforms.

As required by law, each year the Commission makes recommendations regarding how payments should change for the coming year for services furnished under FFS Medicare. In making its determination, the Commission considers beneficiary access to services, the quality of care, providers' access to capital, and Medicare payments in relation to providers'

costs to treat Medicare beneficiaries (referred to as the Medicare margin). In evaluating the adequacy of Medicare's payments, the Commission examines the level and distribution of Medicare margins across each sector and the ability of "efficient" providers to maintain relatively low costs and high quality of care.

This year, we recommended no update payments to IRFs and LTCHs for fiscal year 2014, concluding that providers in those sectors will be able to continue to provide appropriate access to care under current payment rates. For payments to SNFs and HHAs, we reiterated our previous recommendations to lower the level of payments and restructure the PPSs to base Medicare's payments on patient characteristics, not the amount of services furnished. In making these recommendations, the Commission considered the double-digit Medicare margins both sectors have experienced for many years (we estimate Medicare margins in 2013 to be 12 percent for HHAs and 12 percent to 14 percent for SNFs) and their incentives to furnish services for financial rather than clinical reasons and to select patients with certain care needs over others.

The Commission also assesses whether additional policies are needed to influence provider and beneficiary behavior. With poor definitions of the PAC products and a lack of clarity regarding who needs PAC services and how much service is appropriate, the sector is open to potential abuses from providers. Highly questionable patterns of home health care use led the Commission to recommend expanded medical review activities and the suspension of payments to and enrollment of new providers in areas with significant fraud. When providers tailor the amount of service they furnish to take advantage of the designs of the payment systems, Medicare spending can increase even though the care needs of patients did not similarly change. To engage beneficiaries in evaluating their use of home health care, the Commission also recommended a modest copayment for home health services not preceded by a hospital stay.

We recognize that managing updates and PPSs will not address the fundamental problem of paying providers regardless of the quality or the value of these services. To address these problems, two approaches must be taken. First, payments within Medicare FFS need to

encourage quality and care coordination to the extent possible, by—for example— instituting penalties for excessive readmission rates or tying a portion of payments to quality outcomes. Second, Medicare must shift away from FFS payments and toward integrated delivery systems such as bundled payments and accountable care organizations (ACOs).

Reforms that promote care coordination

The Commission has worked on three broad reforms that encourage better care coordination among settings: bundled payments, ACOs, and aligned readmission policies across settings. Bundled payments and ACOs encourage providers to coordinate care to focus on managing patient outcomes and controlling costs. These reforms require providers to accept financial responsibility and accountability for care that extends beyond their immediate purview. Aligned readmission policies would create parallel incentives for hospitals and PAC providers to avoid unnecessary rehospitalizations. Many Medicare Advantage (MA) plans' policies deviate from FFS policies and are likely to be contemplated by entities participating in bundled payments or ACOs. For example, some MA plans are better at coordinating care across settings than others, some pay for home health care on a per-visit basis, and others do not require a prior three-day hospital stay for SNF care.

Bundled payments and risk-based ACOs

Under bundled payments and risk-based ACOs, Medicare would pay an entity for an array of services over a defined period of time. Under bundled payments, one payment bundle would cover all PAC services following a hospitalization. Under an ACO, participating health care providers assume some financial risk for the cost and quality of care delivered to a defined population and share in savings if they can limit costs while maintaining quality. Given the wide variation in PAC use, both reforms could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments would give providers not ready or unable to participate in ACOs a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments for PAC services in 2008 and since then has examined a variety of bundle designs. Today, the Commission releases its June report, which includes a chapter describing the pros and cons of key design choices in bundling PAC services: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish.

We also laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS. Though a single payment to one entity would create stronger incentives to furnish an efficient mix of services, many providers are not ready to accept payment on behalf of others and, in turn, pay them. Alternatively, providers could continue to receive payments based on FFS. To encourage providers to keep their spending low, a risk-adjusted episode benchmark could be set for each bundle, and providers could be at risk for keeping their collective spending below it. In establishing the spending benchmarks, current FFS spending levels may not serve as reasonable benchmarks given the FFS incentives to furnish services of marginal value. The return of any difference between actual spending and the benchmark could be tied to providers meeting certain quality metrics to counter the incentive to stint on services. For beneficiaries, bundled payments should improve care coordination and reduce potentially avoidable rehospitalizations.

Two-sided risk ACOs represent an opportunity to reward providers who control their costs, improve quality of care, better coordinate care, and become more engaged in their care management. The Commission examined CMS's proposed and final rules regarding how benchmark prices would be set, the structure of risk and rewards, beneficiary notification and assignment, and the quality measures ACOs are required to report. We also considered the ability of ACOs to generate savings in markets with high PAC use. We would expect ACOs to have the most success reducing use in markets with the most excess service use, just as we have seen MA plans have success in reducing their bids below FFS costs in markets with the most service use. In our discussions with ACO leaders, they expect to reduce PAC use but

acknowledge they have fewer utilization management tools at their disposal than MA plans. For example, they cannot implement prior authorization, modify service copayments as a way to constrain service use, or change Medicare FFS payment rules in purchasing PAC (such as the 3-day required hospital stay for SNF coverage or payment for a 60-day episode for home health care). If ACOs can lower their PAC use, Medicare could, in the longer term, realize savings.

Expand readmission policies to PAC providers in FFS

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high readmission rates should be penalized. Beginning in October 2012, a readmission policy will penalize hospitals with high readmission rates for certain conditions. To increase the equity of Medicare's policies toward hospitals and SNFs with high readmission rates, last year the Commission recommended payments be reduced to SNFs with relatively high readmission rates, and we are working on similar policies for home health care and IRFs.

The Commission has examined expanding readmission policies to PAC settings so that hospital and PAC incentives are aligned and focused on unnecessary rehospitalizations. If providers are similarly at financial risk for rehospitalizations, they would have a stronger incentive to coordinate care between settings. In addition to minimizing the risks unnecessary hospital stays pose for beneficiaries, rehospitalizations raise the cost of episodes. Among 10 conditions that frequently involve PAC, we found Medicare spending for episodes with potentially preventable rehospitalizations was 70 percent higher than episodes without them (Table 3). Readmissions accounted for one-third of the episode spending. Furthermore, there is large variation in readmission rates, suggesting ample opportunity for improvement. For example, SNF rehospitalization rates for five potentially avoidable conditions vary by more than 60 percent between the best and worst facilities; hospitals' potentially preventable readmissions rates vary even more.

Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging

patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. By creating additional pressure in the FFS environment, the policies would also create incentives to move to bundled payments or ACOs.

Table 3. Lowering readmissions presents an opportunity to improve care coordination and lower Medicare spending

		Mean episode spending		
	Readmission rate	With readmissions	Without readmissions	Ratio of spending for episodes with readmission to those without readmissions
Coronary bypass w/ cardiac catheterization	12%	$51,159	$38,585	1.3
Major small & large bowel procedures	9%	$32,725	$20,747	1.6
Major joint replacement	5%	$32,724	$20,445	1.6
Hip & femur procedures except major joint	8%	$34,629	$25,474	1.4
Stroke	8%	$26,978	$16,624	1.6
Simple pneumonia & pleurisy	8%	$19,071	$8,885	2.1
Fractures of hip and pelvis	7%	$23,318	$15,770	1.5
Kidney & urinary tract infections	9%	$18,309	$9,112	2.0
Septicemia without ventilator 96+ hours	10%	$25,249	$13,726	1.8
Heart failure and shock	13%	$19,244	$9,078	2.1
Average for 10 conditions	9%			1.7

Note: Episodes were initiated by a hospital stay and include post-acute care (home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals), potentially avoidable readmissions, and the physician services furnished during the hospital stay and during institutional post-acute care within 30 days after discharge from the hospital. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities).

Source: Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC.

Reforms to eliminate price differences across settings

The Commission has long believed that PAC providers should be paid based on the characteristics of the patients they treat, not the site of service. As a broad reform, bundled

payments would establish a single price for an episode of care, leaving decisions about the mix of services beneficiaries will receive to providers.

Equal payments for similar PAC services would build on other Commission work examining Medicare's payments for select ambulatory services. Medicare currently pays more for the services furnished in hospital outpatient departments (OPDs) or ambulatory surgical centers (ASCs) than when the same service is provided in a physician's office. Responding to the payment differentials, many services have migrated from physicians' offices to OPDs, and some ASC owners have sold their facilities to hospitals. As a result of these shifts in site of service, Medicare spending and beneficiary cost sharing have increased.

In 2012, the Commission recommended equalizing payments made to OPDs and freestanding physicians' offices for evaluation and management visits. In our June 2013 report to the Congress, we identified other ambulatory services frequently performed in OPDs, ASCs, and physicians' offices for which there are large differences in Medicare's payments, and which can be safely performed in the lower cost setting. The Commission established criteria for selecting potential services related to the mix of sites used, patient severity, similarity of service definitions, and frequency of an associated emergency department visit (which raises the service costs). Narrowing or eliminating payment differences across ambulatory sites for the same service would lower Medicare spending and beneficiary cost sharing.

This year the Commission began an examination of how Medicare could equalize payments for similar patients treated in long-term care hospitals (LTCHs) and acute care hospitals. Medicare pays LTCHs considerably more than acute care hospitals for comparable patients. Furthermore, a study by RTI International used a definition of chronically critically ill to evaluate patients treated in LTCHs and estimated that one-half of patients admitted to LTCHs did not require this level of care.

The Commission is considering various approaches that would establish a uniform payment for comparable patients treated in acute care hospitals and LTCHs, but acknowledges that designing such a policy is difficult. Ideally, payments to LTCHs for patients who do not require this level of care would be lowered and payments to acute care hospitals that treat

LTCH-equivalent patients would be raised, without using criteria that can be gamed by providers. Eliminating payment differences between LTCHs and acute care hospitals would help ensure that acute care hospitals located in markets without LTCHs were not disadvantaged and would dampen the incentive for LTCHs to admit patients who do not require this level of care.

Our efforts on bundling and site-neutral payments are consistent with work sponsored by CMS to evaluate whether payments could be harmonized across PAC settings. In 2012, CMS released its evaluation of a demonstration that collected comparable nursing and therapy resource use and developed a patient assessment instrument to be used across PAC settings. The evaluation found a common set of patient characteristics that explained much of the variation in nursing and therapy costs across settings. The finding indicates a common case-mix measure could be developed across the institutional settings (SNF, IRF, and LTCH), with more analysis required to integrate HHAs into a common system. The other three institution-based settings had more similar costs and could be more readily integrated in a single case-mix system.

Reforms require comparable data across PAC settings

Without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare the costs and outcomes across settings. In 2005, the Commission called for such a common assessment tool so that patients, their service use, and outcomes could be compared across settings. As noted above, CMS completed a mandated demonstration of a common assessment tool in 2011 and concluded that the tool it developed could serve as a single tool for all settings. CMS now needs to outline its plans for how to adopt this tool, or a subset of its elements, across PAC settings and in hospitals.

Comparable patient information is critical to adjusting payments for differences in patients and their care needs. Accurate risk adjustment helps ensure providers do not select certain patients or stint on the care they furnish. Furthermore, as Medicare moves to value-based purchasing, adequate risk adjustment enables fair comparisons of outcomes across providers.

Otherwise, a provider may appear to be inefficient or to have worse outcomes than its "peer" when, in fact, the provider treats sicker patients.

Comparable data is also needed to evaluate the efficacy of settings. One setting may be less costly but have poorer outcomes. The Commission has pushed for risk-adjusted quality measures that gauge patient outcomes, leaving providers and MA plans the task of deciding how to furnish care (the focus of many process measures). The Commission has also discussed the need for a limited set of measures to simplify the myriad of metrics providers and MA plans are required to report.

Because the goal of PAC is often to get the patient home, the Commission has developed measures for risk-adjusted rates of discharge to the community for SNFs and IRFs. Rehospitalization rates—especially for conditions that are potentially avoidable—are also a good gauge of the care furnished, and we now use this measure in evaluating the quality of SNFs, IRFs, and HHAs. We have developed measures for these same three settings that include a period after discharge so that providers have an incentive to coordinate care across settings. Aligning measures across sites allows comparisons of providers' quality and could eventually be used to tie payments to outcomes.

In CMS's demonstration, comparable outcomes data were collected and risk adjusted. The study examined readmission rates and two functional status measures—improvement in self-care and mobility. Some differences among settings were found, but an important take-away is that comparable, risk-adjusted outcomes measures are possible across PAC settings with a common assessment tool. The Commission urges the adoption of common risk-adjusted outcomes-based measures and that CMS move as quickly as practicable to require all PAC providers and acute care hospitals to use a uniform assessment instrument. For sectors currently required to use a different tool, key elements from the common tool could be added to required tools, thus ensuring continuity in running these sectors' case-mix systems used to make FFS payments.

Conclusion

The Commission has recommended and discussed many changes to PAC that would increase the value of Medicare's purchases and improve the coordination of care beneficiaries receive. Some reforms—such as revising and rebasing the SNF and HHA FFS payment systems, adopting a common patient assessment tool, and reporting uniform risk-adjusted outcomes-based quality measures—can be implemented relatively quickly. Others, such as site-neutral payments and readmission penalties, would create more equity across providers in different sectors. These changes could be implemented in the near-term and would serve as building blocks for broader payment reforms—such as bundled payments and ACOs. Because these broad reforms span PAC settings and require providers to assume greater risk, they will take longer to design and implement before they are commonplace. The Commission recognizes the hard work that lies in changing the landscape of Medicare's payments and urges the Congress to begin to make the changes—large and small—necessary to ensure beneficiaries receive more integrated, appropriate, and lower cost PAC.

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

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

Mr. Blum.

Mr. BLUM. So, a couple points.

I mean, one, I think Congress should recognize that there was many changes made to the Affordable Care Act to reduce spending on post-acute-care savings. Of the Medicare savings that were included in the Affordable Care Act, home health, skilled nursing, all the different payment systems did experience payment reductions.

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

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

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

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

Chairman BRADY. Got it. All right.

Mr. Miller.

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

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

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

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

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

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

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

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

One quick, well, you know, wrap up, the Commission has talked about site-neutral payments in the ambulatory setting, with more of that coming out in our report today. Here, we are looking at the site-neutral payment between hospitals and long-term-care hospitals and just beginning to think about some of the relationship between the in-patient rehab facility and skilled nursing facilities.

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

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

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

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

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

Its status, et cetera, I would hand off.

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

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

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

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

Mr. BLUM. Absolutely.

Chairman BRADY [continuing]. For arriving at it and the status of it? That would be very helpful.

Mr. BLUM. Absolutely.

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

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

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

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

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

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

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

Chairman BRADY. Thank you, Mr. Blum.

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

Mr. McDermott is recognized.

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

Chairman BRADY. Okay.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

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

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

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

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

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

Mr. BLUM. I believe, and based upon our work with law enforcement, there is tremendous fraud going on in certain parts of the

country, particularly with home health areas. That has been an extensive focus for our work, to reform payments, to do more HEAT Task Force, working very closely with our partners in law enforcement.

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

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

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

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

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

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

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

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

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

Mr. BLUM. Correct.

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

But, you know, within those contexts, like ACOs, for example, we are very interested to test more flexibility for the 3-day stay, to give more clinical discretion to discharge direct, for example, to the

skilled nursing facility. But it has to be with a common assessment tool, to our belief, and also in a global payment arrangement.

Mr. MCDERMOTT. Now, tell me the difference, if two patients are standing here before us, and one of them is going to go to a nursing home because they—or they need skilled nursing care—they both need skilled nursing care. One of them goes into the hospital and gets admitted, and one of them goes into the hospital and goes into observational status.

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

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

Mr. MCDERMOTT. You have a huge spike.

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

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

Chairman BRADY. Thank you.

Mr. Johnson is recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

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

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

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

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

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

Now, just let me—one other thing. On home health, the story is a little bit different. In home health, when the base rate was created, there were about 30 visits provided over 60 days, and the base rate was based on 60 days. Over time, home health agencies

now provide about 22, 20-some-odd visits per 60 days. They are tilted a little bit more to more skilled visits, but it was based on many more visits.

And, again, here is a situation where the profit margins for the home health agencies have been very high for a decade. And so, once again, we have suggested that the rate should come down. And, just like I told you on the skilled nursing facility side, alter the underlying payment system so you don't harm the home health agencies that take the complex patients.

I am sorry that was so long.

Mr. JOHNSON. That is all right.

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

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

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

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

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

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

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

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

Mr. JOHNSON. Thank you for your response.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you, Mr. Johnson.

Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman.

I want to thank our witnesses for your testimony.

I think this is an important hearing. I think there is tremendous opportunity to enhance the quality of care in the post-acute-care setting, at a substantial cost savings as well. But it is frustrating, because this is really a subset of a larger issue that we are trying

to get at, overall health care reform. I think MedPAC has done a good report, and CMS has been dialed in on the utilization variation that exists throughout the country and certain outliers, as Dr. McDermott just pointed out.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. BLUM. Absolutely.

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

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

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

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

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

But the tradeoff really is speed versus——

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

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

Mr. KIND. Okay. Thank you.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

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

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

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

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

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

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

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

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

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

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

Mr. MILLER. Well——

Mr. ROSKAM [continuing]. What is the argument for 59? What is the argument against 58?

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

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

Mr. MILLER. Hit me one more time?

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

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

Mr. MILLER. And I will say this. And I understand your thinking here, and it is thinking that was very consistent with my own. But, for example, I don't know how many years ago now, I am going to say 7 or 8 years ago, the Commission has been pushing

on the need for criteria for long-term-care hospitals. I have many times sat with the industry and said, where are the criteria? And it has been pulling teeth.

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

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

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

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

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

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

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

Chairman BRADY. Thank you.

Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman.

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

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

Do we know who they are?

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

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

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

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

Mr. BLUM. I think, traditionally, we have been focused on the providers. I think there are some instances where the beneficiaries are complicit, whether they know it or not, that their IDs got stolen. But I think, to us, we have to move away from the past pay-and-chase system and move toward a smarter, wiser system to stop payments before they happen.

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

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

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

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

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

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

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

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

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

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

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

Mr. PASCRELL. Thank you very much.

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

Chairman BRADY. Thank you.

Dr. Price.

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

And I want to thank our witnesses.

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. BLUM. Well, we have cost report processes where we collect costs based upon the costs of care that are submitted to us by CMS.

But it is really the cost of—excuse me, to CMS. But it is really the cost of the care provided to that beneficiary.

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

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

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

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

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

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

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

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

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

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

Chairman BRADY. Thank you. Thank you, sir.

Mr. Buchanan.

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

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

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

And the second thing, I am just concerned about a lot of patients. I am from Florida. It is a big issue in our area. I am very concerned about patients having access to quality care and that a lot

of them might be exempt as a result of going from 60 to 75 or whatever that number might be. So I would ask you that question.

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

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

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

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

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

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

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

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

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

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

This is a big issue all over Florida. I know that Dr. Price mentioned there are 227 Members on a bipartisan basis. Someone like

myself that has been in business 30 years, the whole concept of competitive bidding or bidding, you have to make sure these are legitimate bids, and "legitimate" meaning people can deliver based on what they are talking about under these contracts.

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

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

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

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

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

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

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

Mr. BUCHANAN. Thank you, Mr. Chairman.

Chairman BRADY. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

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

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

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

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

Mr. MILLER. We did.

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

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

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

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

Mr. SMITH. Okay.

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

Mr. SMITH. Okay. Thank you.

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

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

Sorry.

Mr. SMITH. Okay. Thank you.

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

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

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

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

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

Mr. SMITH. Okay. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Gerlach.

Mr. GERLACH. Thank you, Mr. Chairman.

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

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

Mr. BLUM. [Nonverbal response.]

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

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

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

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

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

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

Mr. MILLER. Complicated.

Mr. GERLACH [continuing]. Complicated situation.

Mr. MILLER. Uh-huh.

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

Mr. BLUM. I would agree with you.

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

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

Mr. GERLACH. Mr. Blum.

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

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

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

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

Mr. GERLACH. Okay.

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

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

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

Mr. BLUM. I think that is a helpful suggestion. I would have to become more familiar with this case. We do have short-stay outlier mechanisms in our home health payment system. But, as Mark

said, the current home health payment system is based upon a visit assumption that is no longer valid.

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

Mr. GERLACH. Thank you.

Chairman BRADY. Thank you.

Mr. McDermott, for a brief follow-up.

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

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

Chairman BRADY. And briefly, please.

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

Mr. MCDERMOTT. So you have not used it.

Mr. BLUM. Yet.

Mr. MCDERMOTT. Thank you.

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

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

Chairman BRADY. With that, the subcommittee is adjourned.

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

[Submissions for the Record follow:]

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Statement

of the

American Hospital Association

before the

Health Subcommittee

of the

Committee on Ways and Means

of the

U.S. House of Representatives

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

June 14, 2013

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to provide input on proposals to reform Medicare's post-acute care payment systems. While the AHA supports efforts to bring meaningful reform to the post-acute care field, many of the proposals highlighted in the president's fiscal year (FY) 2014 budget proposal, and the proposals and research currently under development by the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare & Medicaid Services (CMS), include arbitrary cuts that would threaten patients' access to post-acute care services.

Our detailed concerns follow.

THE PRESIDENT'S FY 2014 BUDGET

Market Basket Update

In recent years, post-acute care providers have faced congressional scrutiny that has resulted in substantial payment cuts. Regulatory and statutory payment reductions and restrictions have been considerable for all four post-acute care sectors – long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health (HH) providers. *The Patient Protection and Affordable Care Act of 2010* (ACA) included productivity offsets and other reductions to updates, quality reporting requirements and significant HH cuts. Additionally, CMS has implemented further major payment and operational changes. Most recently, post-acute care providers have endured reductions as a result of the *Budget Control Act's* sequestration.

Despite these numerous payment reductions, the president's FY 2014 budget proposal calls for an additional market basket reduction for all post-acute care providers that would result in a $79 billion payment cut over 10 years. **Given the number and magnitude of the cuts already faced by the post-acute sector, the AHA opposes these additional market basket cuts.**

IRF 60% Rule

The "60% Rule" helps define IRFs by requiring that 60 percent of cases have one of 13 qualifying medical conditions. **The AHA opposes the president's FY 2014 budget proposal to return the threshold for this rule to the 75-percent level.** The president's budget proposal overlooks the fact that IRFs continue to treat sicker patients every year and simultaneously produce better outcomes. Increasing the threshold is also unnecessary, as IRFs already face stringent admission controls, which were tightened in 2010, and yield a distinct IRF patient population. Finally, it would impose a barrier to IRF services that is excessive and unwarranted.

IRF-SNF Site Neutral Payments for Certain Procedures

The president's FY 2014 budget proposal also proposes to reduce IRF payments to a SNF-comparable rate for three conditions. **The AHA opposes this effort because IRFs and SNFs are not comparable settings.** IRFs exclusively treat patients who require both hospital-level care and intensive rehabilitation after an illness, injury or surgery, and are prohibited from treating SNF-level patients. Only in an IRF do beneficiaries receive three-plus hours of therapy per day as part of a plan of care that is developed and overseen by a specialty physician and carried out by an inter-disciplinary medical team. As a result, the patient population and scope of services found in IRFs are unique from those found in SNFs and other settings. In addition, IRFs are required to submit data that show that IRF patients are continuing to produce improved functional outcomes – even as the overall severity of IRF patients increases. Finally, CMS reported in the August 2011 SNF final rule that IRFs have a far higher rate of discharging patients to the community (IRFs: 81 percent; SNFs: 46 percent), and a far lower readmission rate (IRF: 9.4 percent; SNF: 22.0 percent).

CMS'S FY2014 LTCH PROPOSED RULE

The AHA is extremely concerned about two provisions in CMS's LTCH prospective payment system (PPS) proposed rule for FY 2014 – CMS's plans to allow the current "25% Rule" relief to expire, and its current research on major reforms for the LTCH PPS. Both of these changes would inhibit the ability of LTCHs to continue the treat the sickest patients – a role that is notably distinct from other provider settings. They are overly drastic and ill-timed given the fundamental transformation of the delivery system that is in process.

LTCHs are adapting to a wide array of regulatory demands, including the rollout of the LTCH quality reporting program, the transition to ICD-10, implementation of electronic health records, and efforts to integrate with other providers and payers in their communities. These adaptations, when paired with the pending paradigm shift toward paying for value instead of volume, present LTCHs with substantial regulatory fluctuation. Given this environment, the AHA urges CMS to avoid further exacerbating this demanding period of transitions and instead maintain the current 25% Rule relief.

In addition, CMS is researching a policy that would shift payments for a majority LTCH patients from the LTCH PPS to the inpatient PPS. CMS estimated that, under this research, 67 percent of LTCH cases would be subject to inpatient PPS-level payments. The remaining patients – those whom CMS would deem chronically, critically ill (CCI) – are a subset of the highest-acuity patients treated in LTCHs and their cases would continue to be paid under the LTCH PPS. The agency defines CCI patients as those who received eight or more days of intensive care unit (ICU) services during the prior stay in a general acute care hospital, and having a qualifying medical condition.

This policy would be a draconian way to achieve CMS's prior goals for the LTCH PPS, as stated in 2012 and before, of establishing criteria to more clearly define the types of patients admitted to LTCHs. We are deeply concerned that CMS has not adequately justified the need for such extreme reforms. High-acuity beneficiaries treated in LTCHs receive a very focused scope of clinical service that is uniquely concentrated on this population, and which should be preserved. **Therefore, the AHA will urge the agency to reconsider the extreme scope of its current research and instead concentrate on less severe means of raising the minimum clinical standards for LTCHs.**

MEDPAC RESEARCH

At MedPAC's April meeting, staff discussed reform approaches that would eliminate the LTCH PPS and make all payments for LTCH services under the inpatient PPS. These reforms define a new subcategory of patients – CCI patients – a subset of the high-acuity for whom LTCHs would receive an increased inpatient PPS payment. MedPAC defines CCI patients as patients receiving eight or more days of ICU services in either an LTCH or during an immediately prior stay in a general acute hospital. MedPAC estimated that 40 percent of LTCH patients meet the CCI definition.

The AHA agrees with MedPAC's long-standing calls for more stringent LTCH patient and facility criteria, and we support policies that redirect to other settings LTCH patients who do not represent high-acuity, long-stay cases. However, MedPAC's current research is a notable

departure from its prior goal for the LTCH PPS, as stated in 2012 and before, of establishing criteria to identify the types of patients who would benefit from the unique services LTCHs provide. This research makes a dramatic and unfounded leap beyond addressing the problem of LTCHs treating patients who are not both long-stay and high-complexity cases. The options emanating from this research could dramatically lower payments for high-severity cases that do not fall into the CCI category, and potentially lower payments substantially, even for CCI cases.

We are deeply concerned that the commission has not adequately justified the need for such extreme reforms, especially considering how drastically they differ from its prior goal of using criteria to define the type of patient who is appropriate for admission to an LTCH. Rather than continuing on this radical path toward elimination of the LTCH PPS, we urge consideration of more reasonable reforms that would maintain the LTCH PPS for a narrower range of appropriate cases.

MEANINGFUL REFORM PROPOSALS

Criteria

The AHA supports legislative efforts to raise minimum standards for LTCH admissions. In the 112th Congress, Senator Pat Roberts of Kanas and Senator Bill Nelson of Florida introduced S. 1486, *the Long-Term Care Hospital Improvement Act*. This bill would have established both patient and facility criteria for LTCHs in order to make the LTCH setting even more distinct by further concentrating services on treating the sickest beneficiaries. *The Long-Term Care Hospital Improvement Act* sought to proactively define LTCHs and ensure LTCHs concentrate on the highest-complexity, long-stay patients. The AHA continues to advocate for the passage of this important reform proposal. This legislation is an important step toward delivery system reform since it distinguishes a unique LTCH role in communities that are reshaping their local delivery system.

Other Solutions to Improve Care

The AHA believes we need real reform, not the further ratcheting of post-acute care provider payments as outlined in the president's budget proposal, and by CMS and MedPAC. Please find attached a bipartisan list of alternatives to cutting payments for hospital services. Some options Congress should consider specific to post-acute care providers include:

- Develop programs to coordinate care across settings for individuals eligible for both Medicare and Medicaid
- Eliminate barriers to developing integrated care models, such as the LTCH 25% Rule, the IRF three-hour rule and the SNF three-day stay requirement
- Improve programs to enhance care at the end of life

Deficit Reduction Alternatives in Health Care

Summary of the Issue

Measures to curb federal spending by trimming Medicare and Medicaid payments are options in the current deficit reduction environment. Providers already face billions of dollars in Medicare and Medicaid payment cuts. Efforts to further cut Medicare and Medicaid payments to providers jeopardize access to high quality health care services for America's seniors and the poor. True entitlement reform and approaches to change the health care delivery system are needed – not provider cuts.

As congressional leaders and the administration have debated deficit reduction, several "plans" and proposals have emerged. These include:

- President Obama's budget proposals
- House Budget Chairman Paul Ryan's budget proposal
- The Congressional Budget Office's report on options for reducing the Federal deficit
- The National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)
- The Debt Reduction Task Force (Rivlin-Domenici)
- The "Gang of 6" US senators that developed a bipartisan plan to reduce the deficit
- House Majority Leader Eric Cantor's list of spending reductions

These various plans proposed many types of deficit reduction provisions including across-the-board reductions or sequestration, formulaic and deadline-based "triggers" of budgetary action, and specific policy alternatives. Among these options, there are many health care policy alternatives that could be used to support deficit reduction that don't simply cut Medicare and Medicaid payments. The following alternatives should be discussed and thoughtfully considered in any deficit reduction debate:

- Modernizing cost sharing for Medicare and Medicaid
- Increasing the eligibility age for Medicare
- Increasing the FICA tax to support Medicare Part A spending
- Implementing enhanced comparative effectiveness research and programs
- Improving programs to improve care at the end of life
- Developing programs to coordinate care for individuals eligible for both Medicare and Medicaid
- Applying Medicare reforms in the ACA (such as accountable care organizations, medical homes, bundling) to Medicaid
- Increasing use of generic drugs and biologicals
- Modernizing the Medicaid long-term care benefit
- Medical liability reform
- Taxing Cadillac health plans
- Taxing junk foods and sugary drinks

These types of reforms can be used to reduce spending, improve quality, better coordinate care, enhance personal responsibility, and modernize Medicare, Medicaid and the entire health care system.

See table on reverse

Health Care Alternatives for Deficit Reduction

The following table provides more detail describing health care alternatives that were included in one or more of the various deficit reduction proposals and should be considered for deficit reduction.

Option	Description	Plans that include option	10-Year Savings
Medical Liability Reform	Three of the plans included caps on non-economic and punitive damages. The most developed proposal in the CBO Options document would impose certain nationwide curbs on medical malpractice torts, capping non-economic damages to $250,000; punitive damages at $500,000 or two times the value awards for economic damages (whichever is greater); impose a "fair –share" rule (replacing joint-and-several liability); impose a statute of limitations for one year from the date of injury discover for adults; 3 years for children.	CBO Options Ryan Budget Rivlin-Domenici	$62.4 Billion (CBO proposal)
	Modify collateral source rule; impose a statute of limitations; replace joint-and-several liability with a fair-share rule; and create specialized "health courts," allow safe havens for providers who follow best practices.	Simpson-Bowles	$17 Billion
Reduce Medicare Costs by Changing Cost-Sharing Structures for Medicare Part A and B	Establish a single combined annual deductible for Part A and B, along with a 20 percent coinsurance for spending above deductible up to a certain amount.	Simpson-Bowles CBO Options	$32.2 Billion
	Increase the basic premium for Medicare Part B from 25% to 35% of the Program's cost. When Part B began in 1966, the premium was intended to finance 50% of the Part B costs per enrollee.	CBO Options Rivlin-Domenici	$241.2 Billion
	Prohibit Medigap plans from covering the first $550 of an enrollee's cost-sharing liabilities and limit coverage to 50% of the next $5000 in Medicare cost-sharing.	Simpson-Bowles CBO Options Cantor List	Up to $53 Billion
Raise the Age of Eligibility for Medicare to 67	Raise the age of eligibility for Medicare by 2 months every year beginning with people who were born in 1949 until the eligibility age reached 67.	Ryan Budget CBO Options	$124.8 Billion
Pharmaceutical Pricing	Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program. The program would reflect the current rebate system for Medicaid.	CBO Options Obama Budget Simpson-Bowles	$112.0 Billion
	Speed up availability of generic biologics, and prohibit brand-name companies from entering into a "pay for delay" agreements with generic companies. Implement Medicaid management of high prescribers and users of prescription drugs.	Obama Budget	
	Use Medicare's buying power to increase rebates from pharmaceutical companies.	Obama Budget Rivlin-Domenici	
Slow the Growth of Federal Contributions for the Federal Employees Health Benefits Program (FEHBP)	Limit the federal government's contribution to $5,000 towards the cost of an individual premium or $11,000 for a family premium beginning on 1/1/13. The federal contribution would then increase annually at the rate of inflation as measured by the CPI for all urban consumers, rather than at the average weighted rate of change in FEHBP premiums. Simpson-Bowles plan would include a similar pilot program for FEHBP.	CBO Options Simpson-Bowles Cantor List	$31.5 Billion in Mandatory Spending; $41.9 Billion in discretionary spending
Health Care-Related Revenues	Standardize the base on which the federal excise tax on alcohol is levied by using the proof gallon as the measure for all alcoholic beverages.	CBO Options	$59.9 Billion
	Replace the 0.9% surtax on high-income taxpayers with a 1.0 percentage point increase in the total HI tax on all earnings. The HI tax rate for both employers and employees would increase by 0.5 percentage points to 1.95%, resulting in a combined rate of 3.9%.	CBO Options	$650.8 Billion
	Impose a federal excise tax of 3 cents per 12 ounces of "sugar-sweetened" beverage.	CBO Options Rivilin/ Domenici	$50.4 Billion
	Impose the excise tax on employment-based health care coverage above certain limits beginning in 2014 instead of in 2018.	CBO Options	$310 Billion
Base Social Security COLAs and Other Entitlements on the Chained CPI-U	Some policymakers have discussed changing the measure of inflation for Social Security COLAs (CPI-W) and other entitlement program COLAs currently based on CPI-U to the "chained" CPI-U. Social security COLAs are currently based on the CPI-W (consumer price index for urban wage earners and clerical workers). The chained CPI-U (C-CPI-U) is an alternative measure of inflation (also calculated by the Bureau of Labor Statistics) that more fully incorporates the effects of changes in patterns of spending and which most economists and analysts believe more accurately reflects the actual increase in the cost of living.	CBO options (Social Security only)	$112 Billion (Social Security only) Effect on other entitlements unknown

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Statement for the Record
To the House of Representatives Committee on Ways & Means Health Subcommittee Hearing on the President's and Other Bipartisan Proposals to Reform Medicare Post-Acute Care Payments

Introduction

Golden Living is a family of companies that specialize in recovery care. Its mission is to help people recover health and improve quality of life through a network of healthcare services, including rehab, assisted living, skilled nursing care, pharmacy, and hospice. The Golden Living family of companies include Golden LivingCenters, Aegis Therapies, AseraCare, and 360 Healthcare Staffing. There are more than 300 Golden LivingCenters in 21 states. Golden Living also offers assisted living services at more than 30 locations. In addition, the Golden Living companies provide services to more than 1,000 nursing homes, hospitals and other healthcare organizations in 40 states and the District of Columbia. Collectively, the Golden Living family of companies has more than 42,000 employees who provide quality healthcare to more than 60,000 patients every day.

The comments below address several harmful provisions in the President's FY2014 budget proposal and also offer solutions as requested by Committee members:

1. Freezes or cuts to the annual market basket update;
2. Reductions to payments of bad debt;
3. Section 3310 of Patient Protection and Affordable Care Act (PPACA), to reduce cost and waste of medications for Medicare Part D beneficiaries who use post-acute facilities.

We welcome the opportunity to continue working with the Committee to explore solutions to these very important issues.

Total margins must be addressed; Medicare Margin Analysis Provides an Incomplete Picture of Overall Health

The underlying cause of revenue challenges can be correlated to chronically insufficient Medicaid payments. The Medicare Payment Advisory Commission's (MedPAC) own analysis indicated that non-Medicare SNF margins were between -1 and -3 percent, with total margins ranging from 4 to 6 percent in 2011[1]. Medicaid payment "shortfall" has steadily increased every year for the past decade. Nearly

[1] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy.* March 2013.

two thirds of our nursing facility residents are paid for by Medicaid[2], so underpayments of this magnitude have widespread effects, including the inability to properly invest in health information technology (HIT) and severely limited access to investment capital.

Both the President[3] and the MedPAC[4] have recommended a freeze or a reduction to the annual market basket update to SNFs, representing a cut of millions of dollars to our company. The justification for these proposed cuts is, in large part, analysis[5] from MedPAC which has shown double-digit SNF Medicare margins in recent years. However, looking solely at Medicare margins, while neglecting the performance of the sector's other payer sources, provides an incomplete picture of the industry's overall financial health.

Looking at Medicare margins in a silo is short-sighted and provides only a partial view of the overall financial health of the long term and post-acute care industry. Skilled nursing facilities have consistently been underfunded by its largest payer, Medicaid. Market basket cuts do not encourage a more efficient Medicare system and only threaten facilities' ability to provide critical, long term and post-acute care services.

90% of Bad Debt Incurred in Skilled Nursing Facilities is Attributable to Dual Eligible Patients

The federal government requires that beneficiaries who receive care in a SNF to pay their Medicare co-pay beginning on the 21st day of a Medicare-qualified stay. These beneficiaries are either seniors who rely solely on Medicare for cost coverage, or seniors who qualify for both Medicare and Medicaid, also known as dual eligibles. Due to their financial situations, many beneficiaries are unable to cover the Medicare co-pay. In particular, dual eligibles, who are by definition low income, account for more than 90 percent of the bad debt incurred in SNFs. This leaves a gaping hole between the cost of providing care for these vulnerable seniors and the actual payments received for such care in SNFs.

Currently, the Medicare program allows SNFs to turn to the government to recoup some of the cost. With dual eligibles, the federal government allows the state Medicaid programs to provide reimbursement for the unpaid co-payment. However, the statute allows states to pay an amount less than the full co-payment or to elect not to reimburse the co-pay entirely. Because the vast majority of bad debt is directly related to decisions not to cover the cost of the federally mandated copay,

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[2] American Health Care Association 2012 Quality Report, available at: www.ahcancal.org.
[3] U.S. Department of Health & Human Services, *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunities for All Americans*, available at: www.hhs.gov.
[4, 3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy.* March 2013.

our company would be required to deliver millions of dollars in uncompensated care.

Recognizing this imbalance, the federal government has traditionally provided a remedy to allow SNFs to make up much of the cost associated with patients' bad debt. Currently, Medicare reimburses SNFs a portion of the copay that the states fail to provide for dual eligibles, and reimburses a portion of the copay that seniors solely on Medicare are unable to pay. This has been a key element in ensuring SNFs can continue providing care to vulnerable Medicare-Medicaid eligibles.

Prior to the passage of the *Middle Class Tax Relief and Job Creation Act of 2012*, SNFs were reimbursed 100 percent of bad debts for dual-eligible beneficiaries. Then starting in FY 2013 (Oct 2012), the legislation gradually reduced Medicare bad debt reimbursement from 70 percent to 65 percent for non-dual eligibles. Medicare bad debt payment reductions for dual eligibles will be implemented in phases:

- 88 percent in FY 2013 (Starting in Oct 1 2012);
- 76 percent in FY 2014 (October 1 2013); and
- 65 percent in FY 2015 (October 1 2014).

In his FY2014 budget, the President proposes reducing bad debt payments from 65 percent generally to 25 percent for all eligible providers over three years beginning in 2014. This proposal would result in millions of dollars in additional cuts to our company, which has already faced a bad debt cut coupled with multiple other reductions.

Practices for Dispensing Medications in Post-Acute Settings Must be Improved

Costs
The current long-term care pharmacy practice in post-acute settings is to dispense medications utilizing a multi-day, 30 or 14-day, punch card or blister pack model of packaging. This approach results in the provider under Medicare Part A or the Prescription Drug Plan (PDP) under Medicare Part D being billed for the full 30- or 14-day supply of medications upon shipment from the pharmacy to the post-acute setting. This occurs regardless of how long the patient may be in the facility or any changes in the patient's condition that determine how many medications are actually dispensed to the patient.

Waste
Because of the dispensing practice of using multi-day dosages, there is a significant amount of unused medications that results from changes in patient conditions as well as patients being discharged and no longer needing the medications. Recognizing both the financial and environmental impact of this medication waste, several states have implemented actions that require LTC facilities and pharmacies to seek ways to reduce drug waste. One of the early methods used in post-acute settings to reduce drug waste was the process known as "return for credit and

reuse." Over time, however, "return for credit and reuse" has presented significant limitations. This approach does not address:

- Potential savings from the use of lower-cost generics;
- Environmental issues involved with destruction and disposal of unused medications;
- Drug diversion, illegal distribution and use of medications; and
- Drug Enforcement Agency (DEA) requirements with respect to controlled substances.

CMS and the post-acute care community recognize that these are all shortcomings of the current practice and system for dispensing medications in this sector of our healthcare system.

Solutions
As noted, the current system is unnecessarily costly, wasteful, and lends itself to being prone to diversion and error. The optimal solution is to reduce the number of drugs that are actually dispensed and billed by the pharmacy by adopting a single-dosage dispensing system per medication pass by the post-acute clinical staff. That way only the amount of medications actually needed at a given time to meet the patient's prescribed drug regimen are dispensed and charged. This eliminates the source of a majority of the waste from the accumulation of clinically unneeded medications before it occurs.

This led Congress to include a provision in the *Patient Protection and Affordable Care Act of 2010*, Section 3310, that was intended to address in part these problems with the current system.

The Section required that Medicare Part D sponsors and their contracted pharmacies adopt specific and uniform medication dispensing techniques by January 1, 2012. The Section was designed to reduce cost and waste of medications associated with the traditional 30-day supply model for Medicare Part D beneficiaries who use post-acute facilities.

While CMS issued its final rule and implemented Section 3310 in April 2011, providers have been faced with continuing to have to utilize the 30- and 14-day supply method of dispensing. Until very recently there has not been a scalable alternative methodology available that is both operationally and financially feasible to support smaller or single dosage dispensing at the time of the medication pass to the patient.

<u>Remote Dispensing Units</u>
Recent technological advancements have enabled the development of automated remote dispensing units (RDU) for medications in post-acute facilities. The RDU functions as an extension of the institutional pharmacy and its professional staff

through a technology platform that is designed to provide immediate access on a single dosage basis to the most commonly prescribed medications in the post-acute setting.

It is believed that that the availability of these RDUs in post-acute facilities will reduce the amount of unused medications and opportunity for drug diversion, thereby lowering costs while improving medication safety. The RDUs automate several manual, time-consuming medication dispensing processes and procedures. These systems can also deliver enhanced analytics of the impact of medications on patients while increasing the accuracy of patient-care records associated with the administration of the medications to the patients. The automation of these patient recording, assessment, and monitoring functions will give nurses more time to spend in the direct care of their patients.

From a cost perspective since the RDU methodology dispenses medication on a single dosage basis per medication pass, only the amount of the medication necessary for that dose is dispensed and charged. There is virtually no waste of medications or unnecessary charges for the unused medications, compared to what can occur under the current 30- or 14-day post-acute dispensing model.

Many healthcare experts believe that the adoption of a robust and comprehensive remote automated pharmacy dispensing solution will not only save the entire healthcare system billions of dollars over the next 10 years, but will also over time enable the healthcare delivery system to significantly improve the quality of patient care.

Clinical Pharmacy Service

An enhanced clinical pharmacy service based on the active involvement of a clinical pharmacist with the post-acute facility's clinical team (the physician, pharmacist, nursing staff, dietician, physical therapist, etc.) can provide an insightful review and recommendations on key patient-care metrics.

The approach would be to provide the clinical pharmacist with continuous electronic access to the patient's health information and medication regimen for review, thereby enabling timely consultation with the physician and clinical staff of the provider to optimize medication therapy for the patient. In its design, the clinical pharmacist and the automated RDU are totally integrated to ensure that patients' medications are dispensed appropriately, efficiently, and cost effectively for the patient, provider and payer.

The last four years have seen a few post-acute providers become innovators and aggressive advocates for leveraging the benefits of RDU technology being integrated with an enhanced clinical pharmacy service in a new post-acute pharmacy dispensing system. That has resulted in the formalizing of this new concept into a dispensing system for medications that will more effectively meet the needs of post-acute patients and providers.

Conclusion

The post-acute care sector is ripe with new ideas to reform the system. Using the same techniques that have been used in the past as stop-gap measure to curtail spending will only harm the financial viability of the sector and the patients it serves. Congress must look at other avenues to find government savings that do not jeopardize access to critical care.

We are encouraged by the Committee's willingness to consider proposals that do more than simply cut payments to health care providers. The solutions outlined in this statement mean a more efficient system and better quality care for our patients. We look forward to ongoing collaboration with the Committee on these very important issues. For questions or comments, please contact Jack MacDonald, Executive Vice President and Chief Public Affairs Officer, at (202) 347-9928 or jack.macdonald@goldenliving.com

American Medical Rehabilitation Providers Association, AMRPA

Statement of the American Medical Rehabilitation Providers Association (AMRPA) for the House Ways and Means Health Subcommittee Hearing on Medicare Post-Acute Care Reform

Friday, June 14, 2013

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), thank you for the opportunity to provide comments regarding the President's Budget and other proposals to reform Medicare post-acute care payments. AMRPA commends the Committee for convening a hearing on this important topic.

AMRPA is extremely concerned about proposed Medicare and Medicaid cuts to inpatient rehabilitation hospitals and units (IRH/Us, described by Medicare as IRFs). These cuts would severely and negatively impact IRH/Us and the patients they serve. While the cuts may be proposed under the guise of "reform", they are anything but. Rather, they are mostly outdated, pulled-off-the-shelf redistributional proposals that fail to take into account the needs of rehabilitation patients, the changing nature of the health care delivery system and the clinical judgment of expert physicians. To ensure continued access to high quality, medically necessary inpatient rehabilitative care, Congress should oppose further payment reductions to IRH/Us. Additionally, any reforms related to post-acute care should be guided by the fundamental principle that clinical decision making—both with respect to the type and site of care—should determine patient care. We urge Congress to ensure that physician judgment is central to any post-acute care reforms.

I. Rehabilitation Hospitals Provide Critically-Important Care to Individuals Working to Overcome Challenging Injuries, Disabilities and Conditions

Medical rehabilitation is a critical component of the health care delivery system. AMRPA members work daily with Medicare and Medicaid beneficiaries to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement. AMRPA members provide rehabilitation to patients working to overcome some of the most challenging injuries and conditions known, including brain injury, spinal cord injury, musculoskeletal injuries and diseases, stroke, and other neuromuscular problems. Medical rehabilitation prevents unnecessary medical costs in the long-term and allows patients to return to the most important people and activities in their lives.

Members of Congress are familiar with the quality medical care that patients receive in IRH/Us. Rehabilitation hospitals have provided essential and effective care for the spouses, parents, sons, daughters, and other family members of Members of Congress. Congress, along with the rest of the country, has also watched with admiration as Senator Mark Kirk (R-IL) and former Representative Gabrielle Giffords (D-AZ) have recovered from devastating injuries and medical conditions through receiving intensive medical rehabilitation services. With courage and fortitude, these individuals have relearned how to walk, speak, read, and write through rehabilitation hospital care.

As Congress considers changes to the post-acute care sector, it must ensure that patients—our families, friends, and colleagues—are not negatively impacted. Unfortunately, IRH/U's ability to provide quality, effective rehabilitation care is threatened by proposals such as market basket cuts, the 75% Rule, and "site neutral" payments.

II. Congress Should Avoid Further Cuts to IRH/Us, a Sector which has been Cut Significantly and in which Growth Concerns are Minimal

One proposal under discussion would freeze market basket updates for post-acute care providers. Congress should reject this recommendation for IRH/Us, a sector that has been cut significantly in recent years even though no unconstrained growth or spending problems exist. Before considering any further post-acute care cuts, Congress should take into account the significant reductions that are already in place or about to be implemented for IRH/Us.

Congress recently enacted significant cuts for IRH/Us. The Budget Control Act of 2011 included a two percent sequestration cut to Medicare payments. This cut is particularly significant for rehabilitation hospitals/units because on average, 60 percent of patients in IRH/Us are Medicare beneficiaries. The Affordable Care Act (ACA) also subjects inpatient hospitals, long-term care hospitals, IRH/Us, psychiatric hospitals and outpatient departments of hospitals to across the board cuts totaling $156.6 billion over 10 years. Notably, the amount and impact of these cuts will grow over time, meaning that their total impact will not be fully understood in the short-term. It should be noted that the ACA cuts impacted hospital level care provided by IRH/Us and LTACHs, *but do not apply to SNFs or home health.* These hospital and outpatient payment cuts will be incurred in addition to a $4 billion cut (over ten years) to IRH/Us enacted by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA froze the IRH/U market basket update at 0% from April 1, 2008 through the end of Fiscal Year 2009 — the rehabilitation hospital field endured six full quarters without any market basket updates. Rehabilitation hospitals and units simply cannot continue to absorb additional payment reductions without such reductions adversely affecting patient access.

These proposed cuts are unwarranted for IRH/Us. Unlike other post-acute care providers that have experienced explosive growth, rehabilitation hospitals and units have seen dramatic declines in utilization over the past eight years. Since 2003, IRH/Us have had the lowest Medicare spending growth of any post-acute care provider and growth has been negative in three of the last five years. An analysis of eRehabData® shows that the total number of annual Medicare admissions has declined since the third quarter of 2003 by nearly 155,000 patients. A recent Moran Company analysis reported that Medicare IRH/U volume in the second quarter of 2012 is down 24.4 percent from the comparable period in the second quarter of 2004. In addition the number of providers has shrunk from 1,211 in 2003 to 1,162 in 2013, while the number of beds has fallen from 38,765 in 2005 to 38,265 in 2013. This has diminished capacity exactly when the large wave of American baby boomers will be placing increased demand for services on the field. Market basket reductions would further negatively impact patient access to rehabilitation care.

III. The 75% Rule is an Arbitrary Quota System that Wrongly Emphasizes Diagnostic Categories and Numeric Thresholds over the Needs of the Patient

Another proposal calls for an increase of the compliance threshold to 75% beginning in 2014. This policy would require 75% of an IRH/U's patients to have one of 13 specified diagnostic categories before it could qualify as an IRH/U for payment purposes. This policy is known as the "75% Rule," and is one of the Medicare IRH/U classification criteria.

The 75 Percent Rule is a dated policy that has been soundly rejected by Congress in the past. In 2004, the Centers for Medicare and Medicaid Services (CMS) began phasing in regulations in 2004

implementing a new 75% Rule. Congress quickly recognized that the new 75% Rule was adversely affecting access to medically necessary rehabilitation services for vulnerable elderly and disabled patients and placing insurmountable stress on IRH/Us. In order to comply with the 75% Rule, IRH/Us oftentimes were forced to decline admitting patients based on their condition category – despite the fact that they were clinically appropriate for medical rehabilitation.

The Medicare, Medicaid, SCHIP Extension Act of 2007 (MMSEA) permanently reduced the compliance threshold percentage for this classification criterion to 60%. In response to this permanent statutory relief, IRH/Us agreed to self-fund this regulatory fix through supporting a 0% market basket update from April 1, 2008 through the end of Fiscal Year 2009—six full quarters without a payment update. No other post-acute care providers or hospitals were subject to this or any comparable reimbursement cut. In addition, Congress directed CMS to conduct a study and analysis of the 75% Rule, which was performed by RTI and released by CMS in September 2009. The study did not recommend changing the current compliance threshold percentage of 60%.

There were many good reasons why Congress soundly rejected the 75% Rule. As expressed by the MedPAC Chair and Deputy CMS Administrator in recent Ways and Means Committee hearings, the 75% Rule is a "crude" and "arbitrary" standard.[1] The 75% Rule is an arbitrary quota system that wrongly emphasizes diagnostic categories and numeric thresholds as a defining characteristic of IRH/Us. The policy is not a standard by which to judge the medical appropriateness of individual patients. Indeed, the arbitrary nature of the policy was evident in 2004 when CMS began enforcing the new 75% Rule. Because of IRH/Us' need to manage to the percentage threshold, there were many instances in which patients were accepted for admission one month, while patients with the same condition and clinical profile and in need of the same treatment were not able to be admitted the following month. The 75% Rule had the effect of overriding physician decisions and patient needs in order to achieve regulatory compliance.

The dated 75% Rule policy also fails to take into account current regulatory requirements facing IRH/Us. CMS adopted new, more restrictive medical necessity coverage criteria in January 2010.[2] Under these criteria, every patient admitted to an IRH/U is subject to an intensive pre-admission screening to determine the appropriateness of intensive rehabilitation therapy. This review must be completed by a licensed rehabilitation physician within 48 hours immediately preceding the IRH/U admission and must be documented in the patient's medical record. Following admission, the rehabilitation physician must conduct a post-admission review within 24 hours to ensure the patient remains appropriate for treatment in an IRH/U and to begin the development of the patient's course of treatment. A rehabilitation physician must then develop a plan of care within four days of the patient's admission to the IRH/U. The plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRH/U stay, thereby supporting the medical necessity of the admission. In effect, these stringent criteria currently serve as a "100% Rule", with all IRH/U patients subject to extensive scrutiny before and after admission to the IRH/U. This policy has further constrained growth and admissions in a significant way.

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[1] Testimony of Glenn Hackbarth, J.D., M.A., Chairman, Medicare Payment Advisory Commission (MedPAC) before the U.S. House Ways and Means Health Subcommittee, May 15, 2013.

[2] *See* Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered under Part A, 110.

Additionally, the ten-year old 75% Rule recommendation does not adequately reflect the advances in medical care and technology that have created new populations who require inpatient hospital level rehabilitation. These include, among others, patients with cancer, cardiac diseases, pulmonary diseases, organ transplants, and artificial heart pump implants. Even with these new populations, inpatient rehabilitation spending as a percentage of Medicare has been declining and now is essentially flat.

Some proponents of the policy change maintain that the government would realize savings from new implementation of this policy. However, in reality the federal government is unlikely to realize such savings. In response to the 75% Rule, IRH/Us irreversibly modified their admission practices to come into compliance and reduce costs. Patients were shifted to skilled nursing homes (SNFs) or home health agencies. The highest percentage of Medicare patients now being treated in IRH/Us includes extremely medically complex individuals with complicated diseases, conditions and other neurological impairments that are more severe, more costly to manage, and require longer lengths of stay. These patients simply could not and would not receive the appropriate intensity of care in other post-acute care settings, such as nursing homes.

IV. Shifting to "Site Neutral" Payments is a Redistributional Proposal that Fails to Recognize the Differences between Sites of Post-Acute Care

Another troubling proposal would implement a policy to "equalize payments for certain conditions treated in IRFs and SNFs." The proposed payment policy would immediately apply to three conditions involving hips and knees as well as pulmonary conditions, and also provides broad discretionary authority to the Secretary to add other conditions. This proposal is usually referred to as "site neutral payment."

This proposal is deeply flawed. Site neutral payment policy fails to consider the clinical needs of patients in making decisions about the best course of care. In addition, it does not take into account the fundamental differences in staffing quality, outcomes and levels of care among post-acute care providers. It also fails to recognize the stringent requirements placed upon IRH/Us that do not apply to other post-acute care providers such as nursing homes. Site neutral payments represent a redistributional proposal under which some providers will gain market share of patients and payments at the expense of clinically appropriate, hospital-level, quality care.

Medicare requirements for IRH/Us are stringent and different from other post-acute care providers. To be classified as an IRH/U, the hospital must have a medical director and nurses who specialize in rehabilitation, have 60 percent of admissions come from 13 specific diagnoses, and can only admit patients who need 3 hours of therapy a day and have the potential to meet predetermined goals. No other post-acute care provider faces similar requirements.

Site neutral proposals fail to recognize these fundamental differences in regulatory requirements, staffing levels, and resource utilization between and among sites of care. Congress cannot impose site neutral payment rates without also creating site neutral regulatory standards. In the absence of parallel regulatory, staffing, and cost-structures, Medicare must appropriately compensate IRH/Us. Because IRH/Us only admit patients who require hospital-level care and resources, Medicare must pay hospital-level rates for this level and intensity of care. A proposal to establish "site neutral" payments ignores the IRH/U physician, nursing, hospital infrastructure and related costs that are not covered by SNF rates or required of SNFs.

Numerous studies have demonstrated that patients receiving rehabilitation in the IRH/U setting have superior functional outcomes compared to those treated by other post-acute providers, including stroke patients and hip replacement and hip fracture patients. A report prepared for CMS by RTI found that, generally, stroke patients treated in IRH/Us have greater improvement and shorter stays than stroke patients treated in SNFs.[3] Other studies support these findings. A study by Kramer et al. reported that stroke patients who were treated in an IRH/U achieved greater functional improvement compared with patients treated at a SNF.[4] Many studies have also demonstrated superior patient outcomes when hip fracture patients were treated in an IRH/U.

IRH/Us also achieve superior results in a shorter amount of time compared to other sites of care. The Medicare Payment Advisory Commission (MedPAC) found that IRH/U patients had an average length of stay of 13 days in 2011[5] compared to patients in a relatively efficient nursing home who averaged 34 days in 2009.[6] Studies by independent experts have found similar data. Munin et al. found that IRH/U patients stayed an average of 12.8 days while SNF patients stayed in the facility an average of 36.2 days.[7] SNFs are paid on a per diem basis, meaning that longer lengths of stay increase costs to the beneficiary and the Medicare program.

Moreover, an important measure of quality rehabilitation care is the percentage of patients that are discharged to the community, rather than another acute or post-acute care setting. According to CMS, a significantly higher percentage of IRH/U patients (81.1%) are able to be discharged to home after rehabilitation than nursing home patients to the community (27.8%).[8] Numerous academic studies have also demonstrated that patients who received rehabilitation in IRH/Us return to the community more often than those treated in SNFs.[9]

Interestingly CMS has failed to comprehensively analyze the comparative costs of medical rehabilitation as compared to SNF-level care over an entire episode of care. When one takes into account readmission costs (SNFs have readmission costs twice that of IRH/Us) and the higher percentages of discharge to home and community, for many Medicare beneficiaries, rehabilitative care may be the less costly alternative.

Because rehabilitation hospitals and units are able to deliver high quality care that enables most patients to return home more quickly, the Center for Medicare Advocacy and others recognize that any cost savings per treatment episode to be achieved by shifting patients from IRH/Us to other

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[3] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, p. 212 (March 2011), http://www.medpac.gov/documents/Mar11_EntireReport.pdf.

[4] Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

[5] MedPAC March 2013 Report to Congress.

[6] *Id.* at 163. *See also* Centers for Medicare and Medicaid Services, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012, 76 Fed. Reg. 48486, Aug. 8, 2011.

[7] Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72.

[8] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012 Final Rule, p. 48499 http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf (last visited October 25, 2011) and MedPAC March 2013 Report to Congress.

[9] Walsh MB, Herbold J: Outcome following rehabilitation for total joint replacement at IRF and SNF: A case-controlled comparison. *Am J Phys Med Rehabil* 2006; 85:1-5. Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72. Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

providers will be minimal at best. Rather than simply comparing per day costs of IRH/Us and nursing homes, total costs per episode of care should be compared. As noted above, significantly longer lengths of stay, higher readmissions and lower rates of discharge to the community from SNFs add significant costs to the Medicare program that are not accounted for when simply comparing per day costs. In addition to considering costs, the comparative quality and scope of care, as well as patients' health status at discharge and beyond, must be considered in order to meaningfully assess whether nursing home care is actually less costly.

V. Congress Should Support Forward-Thinking and Effective Reforms to the Post-Acute Care System, Including Implementation of the Continuing Care Hospital

A. The CCH Would Reduce Costs and Improve Care by Moving to a Patient-Centric Delivery System Model

AMRPA agrees that the post-acute care delivery system should be improved by moving from a facility-centered to a patient-centered payment system and by improving care coordination. AMRPA has long been at the forefront of developing forward thinking solutions to challenging issues. For example, AMRPA developed the Continuing Care Hospital (CCH), a pilot project that will help move Medicare towards a more patient-centric delivery system model in post-acute care. Despite a Congressional mandate in the ACA to implement the CCH, to date CMS has failed to do so. AMRPA calls on Congress to ensure that CMS implements this important pilot.

The envisioned CCH is an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs that are organized, in part, to deliver intensive rehabilitation therapy programs, as well as the medical component. The CCH could be an actual building (a hospital offering some or all three levels of care) or a virtual entity (an organization that provides under common management most or all of the three levels of care in more than one building or unit).

CCHs could operate distinct units or distinct levels of service that correspond to different levels of care recognized by Medicare. A physician would make the admission decision regarding whether a patient should receive care within the CCH and also determine which intensity of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics. Creation and use of performance and outcome measures are a critical component of the model. This model centers admission, treatment, and payment decisions on the needs of the patient, rather than concentrating on the specific type of the provider of care.

By focusing on the post-acute care hospital continuum, the CCH provides an innovative delivery system model and an alternative to some of the concepts proposed by the Medicare Payment Advisory Commission (MedPAC), the Obama Administration, and the Senate Finance Committee, including total acute and post-acute care bundling. The CCH model will improve quality by allowing for appropriate care based on patient need, removing barriers to access caused by the current provider requirements and payment systems, and promoting collaboration.

Additionally, the CCH model will decrease costs by creating efficiency and eliminating regulatory and administrative costs, avoiding confusing post-acute care requirements, and eliminating the costs of multiple admissions.

B. The Agency has Failed to Implement the CCH Pilot Despite a Congressional Mandate to do So

Unfortunately, this pilot has not been implemented by CMS despite a statutory requirement to do so. Under the ACA, the Secretary of the Department of Health and Human Services (HHS) must implement the CCH Pilot. Section 3023 of the ACA requires the Secretary to conduct a National Pilot Program on Payment Bundling. The ACA goes on to state that the Secretary "*shall*" (emphasis added) apply the provisions of the bundling program "to separately pilot test the continuing care hospital model." [10] The use of the term "shall" takes discretion from the Secretary with respect to implementation of the CCH. The language is clear—Congress has required the Secretary to test the CCH model.

In establishing the CCH model, the statute states that "the provisions" of the bundling pilot shall apply to the CCH with a few defined exceptions.[11] One of the provisions applicable to the bundling pilot—and by extension to the CCH model—is the effective date. The bundling pilot is to be implemented "not later than January 1, 2013." The failure by the Secretary to establish the CCH pilot by this date was a clear violation of the statute. To date, the Agency has shown no progress towards implementing this pilot.

C. The Agency's Bundling Initiatives Do Not Satisfy the Spirit of the Law

Some in the Agency have argued that CMS has complied with the "spirit" of the law by implementing various bundling pilot projects. This contention fails on its face. Because Congress requires the Secretary to test the CCH concept, an assertion that the Secretary and Department pursued the spirit of the law falls short. Even if one accepts that implementing a statute should proceed through an amorphous understanding of the spirit of the law, CMS' contention that is has followed the spirit of the CCH section fails on both interpretive and practical grounds.

First, such an argument misinterprets the spirit of the law. It is clear from the drafting of the statute that Congress intended that the CCH be tested. The CCH model is listed in two separate portions of the statute. The first section, as described above, requires that the CCH be tested as part of the National Pilot Program on Payment Bundling. However, Congress also took further steps to ensure the CCH model would be implemented. Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation (CMMI) and lists specific, detailed models the Secretary may test. One of these models is the CCH.[12] By including a second statutory section discussing the CCH, Congress is establishing a backstop to ensure that the Secretary implements the model. That the Congress would go to such lengths to ensure implementation of the CCH demonstrates the project's importance to Congress. The Secretary must implement the CCH because it is required by statute and consistent with legislative intent.

Additionally, implementing bundling demonstration programs does not fulfill the statutory requirement to test the CCH because of the fundamental differences between the bundling pilots and the CCH concept. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments as part of the Bundled Payment for Care

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[10] Sec. 10308 of the ACA.
[11] *Id.*
[12] Sec. 3021 of the ACA.

Initiative (BPCI). Unfortunately, these four models are so different in practice from the CCH that they do not fulfill the statutory mandate to implement the CCH.

As noted above, the list of CMMI's potential projects includes the CCH. Thus, in theory, the CMMI could satisfy the statutory mandate to test the CCH concept if it were to engage in a CCH pilot; however, the Agency has not done so with the BPCI. The statute authorizes the CMMI to implement a model of "continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or nursing care during an inpatient stay and the 30 days immediately following discharge."[13] None of the four bundling models meet this definition of the CCH.

Model 1 of the bundling initiative is titled "Retrospective Acute Care Hospital Stay Only." The episode of care for this model would be defined as the inpatient stay in the general acute care hospital. Because the CCH focuses on a stay in a comprehensive CCH plus 30 days after discharge, this model is not similar to the CCH.

Model 2, "Retrospective Acute Care Hospital Stay plus Post-Acute Care," comes closer to fitting the CCH characteristics but still does not meet the statutory mandate to test the CCH concept. In Model 2, the episode of care would include the inpatient stay and post-acute care and would end, at the applicant's option, either a minimum of 30 or 90 days after discharge. This model differs from the CCH because there is no indication that the model integrates care like the CCH. One of the benefits of the CCH is its emphasis on eliminating silos of care and basing treatment decisions on what is best for the patient. There is no indication that Model 2 would achieve these ends.

Model 3, Retrospective Post-Acute Care Only, would begin at the initiation of post-acute care and would include the participation of a SNF, IRF, LTCH or Home Health Agency (HHA). Again, because the care is not integrated, this model does not satisfy the requirement to test the CCH.

Finally, Model 4, Acute Care Hospital Stay Only, involves only the inpatient stay. Because the CCH focuses on post-acute care, Model 4 does not satisfy the requirement to test the CCH.

That the BPCI does not work as a substitute for the CCH is borne out by the experiences of a number of rehabilitation hospitals/units. A significant number of rehabilitation hospitals submitted letters of intent and attempted to participate in the BPCI but could not because of the structure and design of the project as well as problematic data issues. Indeed, it is questionable whether the Agency has found any entities meeting the definition of CCH that are able to participate in the Initiative. Inability to do so may, in fact, demonstrate a disconnect between the requirements of the Initiative and the characteristics of the CCH.

For all these reasons, implementation of the BPCI does not fulfill HHS' statutory requirement to implement the CCH model pilot in Section 3023. We request that the Committee use its oversight authority to ensure implementation of the CCH pilot by CMS.

VI. Conclusion

Thank you for the opportunity to provide comments on this important issue. AMRPA looks forward to working with the Committee to ensure patients continue to have access to medically-

[13] Sec. 3021 of ACA.

necessary medical rehabilitation care. If you have any questions about these recommendations, please contact Carolyn Zollar (czollar@amrpa.org) at 202-223-1920 or Martha Kendrick (mkendrick@pattonboggs.com) at 202-457-6520.

Sincerely,

Marsha Lommel, MA, MBA, FACHE
President and Chief Executive Officer
Madonna Rehabilitation Hospital
Chair
AMRPA Board of Directors

Coalition to Preserve Rehabilitation, CPR

PROTECT REHABILITATION SERVICES CRITICAL TO MEDICARE BENEFICIARIES WITH INJURIES, ILLNESSES, DISABILITIES AND CHRONIC CONDITIONS

WRITTEN TESTIMONY ON PROPOSALS TO REFORM MEDICARE POST-ACUTE CARE BEFORE THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE JUNE 28, 2013

Thousands of individuals with disabilities and chronic conditions utilize Medicare to access the rehabilitation services they need to remain healthy, functional, and live as independently as possible in their homes and communities. According to the Centers for Medicare and Medicaid Services (CMS), more than two thirds of Medicare beneficiaries, or about 21.4 million individuals, had at least two chronic conditions in 2010.[1] To these individuals and others with injuries and illnesses, Medicare is a lifeline to a better quality of life through improved health and functional status.

In connection with the June 14 hearing to examine the President's and other bipartisan Medicare proposals related to post-acute care, the House Ways and Means Health Subcommittee is considering numerous changes to the Medicare program that impact people requiring varying levels of rehabilitative care in inpatient and, potentially, in outpatient settings. We hope the Subcommittee is sensitive to the importance of preserving access to high quality rehabilitation care under the Medicare program. Senator Kirk, Senator Johnson, and former Congresswoman Gabby Giffords offer compelling examples of how comprehensive rehabilitation leads to a return to health, function, and independent living.

As representatives of people with disabilities and chronic conditions and providers who serve them, the undersigned organizations of the Coalition to Preserve Rehabilitation recognize the importance of Medicare reforms that prolong and strengthen the long term viability of the program. However, we have serious concerns with efforts to unduly focus Medicare spending reductions in settings in which post-acute care is provided, particularly in inpatient rehabilitation hospitals and units (IRH/Us) as well as outpatient therapy services.

Overall, Medicare spending growth has been extremely low over the past three years and the Congressional Budget Office has projected this historically low rate of growth as contributing hundreds of billions of dollars in deficit reduction. In addition, Medicare data establish that spending

[1] CMS Chartbook 2012: Chronic Conditions Among Medicare Beneficiaries, P. 6: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf

in the IRH/Us setting has remained relatively flat over the past decade due in part to policy changes made by previous Congresses.

As members of the Coalition to Preserve Rehabilitation (CPR), we strongly believe that any changes to the Medicare program should not have the effect of impeding access to rehabilitation and other post-acute care services. Congress should avoid proposals that decrease short-term healthcare expenditures by simply shifting costs to beneficiaries, decreasing benefits, or erecting policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet their individual rehabilitation needs in terms of amount, duration, intensity and scope of rehabilitation services.

A number of pilots and demonstrations authorized under existing Medicare law are already reforming the Medicare post-acute care system and these reforms ought to be given time to achieve their promise. New delivery models that focus on persons with multiple chronic conditions are in their infancy and should be give time to demonstrate their value. Bundling proposals are being pursued that have not yet had the opportunity to produce meaningful results and CMS has not even implemented some existing programmatic requirements to date (i.e., the Continuing Care Hospital pilot program). These and other programs should better align financial incentives with coordination of high quality care and prioritize care provided in the home and community while preventing unnecessary institutionalization, readmissions, and promoting person-centered care and decision making.

Inpatient Rehabilitation Hospital Proposals

With respect to some of the post-acute care proposals currently being considered by the Committee, the Coalition to Preserve Rehabilitation opposes policies that would severely restrict access to IRH/U services for Medicare beneficiaries with injuries, illnesses, disabilities and chronic conditions.

As this Subcommittee considers Medicare proposals that reduce spending to offset the cost of a fix to the physician fee schedule or otherwise reduce the overall deficit, we ask you to NOT include in your legislation the following proposals.

1. **Cuts to Future Investments in Inpatient Rehabilitation Hospitals and Units**
   The magnitude of aggregate reductions in annual inflation updates to IRH/U care included in the President's most recent budget proposal, is completely disproportional to Medicare expenditures in this setting of care. According to the data, Medicare expenditures for IRH/Us has been relatively flat for the past several years, in stark contrast to many other areas of both acute and post-acute care spending under the program. In fact, Medicare spending on inpatient rehabilitation services makes up only 1.2% of total Medicare spending[2] and only 11.4% of Medicare spending on post-acute care services.[3] During the hearing, Jon Blum was specifically asked about appropriate margins and he stated that anytime margins were in the double digits the Agency felt this was problematic. Given that this double digit threshold has not been exceeded it would be inappropriate to impose

[2] CMS National Health Expenditures by Type of Service and Source of Funds, CY 1960-2011, https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage; and MedPAC March 2013 Report to Congress (Table 1).
[3] AMRPA calculation based on MedPAC March 2013 Report to Congress, MedPAC January 2013 Meeting Presentation on Home Health, and MedPAC December 2012 Meeting Presentation on Skilled Nursing Facilities.

market basket reductions. Large spending reductions in post-acute care will deal a serious blow to the capacity of IRH/Us—and all post-acute settings—to accommodate the needs of an aging population with disabling conditions. Inpatient hospital rehabilitation is cost-effective by maximizing the functional capacity of individuals who receive such services. The ability to leave the hospital and live as independently as possible in the home and community-based setting, as opposed to spending long periods of time in institution-based care or being readmitted to the acute care hospital, will avert the need for enormous unnecessary spending for these beneficiaries in future years.

2. **Increasing the 60% Rule for Inpatient Rehabilitation Hospitals and Units**
We oppose raising the 60% rule, which was established by Congress in 2007, up to a 75% compliance threshold, a percentage that would clearly restrict access to IRH/U services. This is an issue that has been debated for several years and that Congress has resolved. Congress settled this debate in the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA") with the implementation of a reasonable rule that has been demonstrated to permit appropriate access to inpatient hospital rehabilitation in the years that have followed. The data clearly establishes that the 60% Rule is working in its current form. Inpatient rehabilitation has not experienced nearly the same increases in Medicare expenditures that other settings of post-acute care have over the past several years. Raising the rule from 60% to 75% would simply take clinical decision-making out of the hands of physicians and the rehabilitation team and place those decisions into the hands of bureaucrats. We strongly urge you to preserve the 60% rule so as to not erect arbitrary barriers to intensive, hospital-based rehabilitative care.

3. **Site-Neutral Payment Proposals**
This proposal would reduce significantly access to inpatient rehabilitation for patients with particular conditions. These conditions, depending on the severity of the patient, are treated in bothIRH/Us as well as Skilled Nursing Facilities (SNFs). The fallacy behind this proposal is that similar patients achieve equal outcomes when treated in either setting. But even the study that the Medicare Payment Advisory Commission (MedPAC) cites for this proposition states that its "results are preliminary, and additional work is needed to define clinically meaningful differences in self-care and mobility functional status." (See, Research Triangle Institute Study, Vol. 4, Sec. 8, page 58.) Implementation of site-neutral payment for patients with hip fractures, joint replacements and other conditions would simply eliminate access to intensive rehabilitation programs by erecting a financial disincentive for admission of these individuals in IRH/Us. This appears to be just another proposal to drive patients to less intensive, less appropriate rehabilitation settings, rather than the setting that best meets their rehabilitation needs.

Outpatient Therapy Services

The Coalition to Preserve Rehabilitation cannot pass up the opportunity in the context of this hearing to express our dismay with CMS's implementation of the exceptions process medical manual review to the Medicare outpatient therapy caps. Although consumer and disability organizations have long opposed these arbitrary caps in therapy benefits, CMS's current use of Recovery Audit Contractors (RACs) to review claims in excess of $3700 per person is highly objectionable. The use of RACs to assess whether therapy services for these beneficiaries are reasonable and necessary creates a

presumption of fraud, abuse and overutilization, and creates a chilling effect on access to services above this $3700 cap.

This cap serves to deny care to the very individuals who need it most, approximately 5% of those requiring outpatient therapy services. This policy has a disproportionate impact on people with disabilities and chronic conditions who utilize therapy services to improve, maintain and prevent deterioration of their function and health status. We ask the Subcommittee to (1) prevent CMS from utilizing RACs to administer the outpatient therapy benefit, (2) extend the exceptions process for the therapy caps beyond December 2013, (3) streamline the exceptions process for those with documented disabilities and chronic conditions, and (4) consider redesigning the physical therapy, occupational therapy and speech-language pathology benefits to focus on functional outcomes rather than arbitrary caps on the benefit.

The disability and chronic illness community understand the magnitude of the problem that our nation faces in attempting to contain federal spending and finally fix the physician fee schedule. However, achieving significant federal savings on the backs of people with disabilities and some of our most vulnerable citizens is not the path to success.

We look forward to working with you to preserve the Medicare program while preserving access to rehabilitation services for all Medicare beneficiaries. Thank you for the opportunity to submit this testimony for the written record. For more information, please contact Peter Thomas at peter.thomas@ppsv.com or (202) 872-6730.

Sincerely,

American Academy of Physical Medicine and Rehabilitation
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America
Center for Medicare Advocacy
Christopher & Dana Reeve Foundation
Easter Seals
National Association of State Head Injury Administrators
National Association for the Advancement of Orthotics and Prosthetics
National Disability Rights Network
Paralyzed Veterans of America
The Arc of the United States
United Spinal Association

HealthSouth

HEALTHSOUTH®

June 28, 2013

Chairman Kevin Brady (R-TX)
House Ways and Means Committee
Health Subcommittee
1102 Longworth House Office Building
Washington D.C. 20515

VIA ELECTRONIC SUBMISSION

RE: Comment Letter on Health Subcommittee Hearing on Proposals to Reform Medicare Post-Acute Care Payments

Dear Chairman Brady:

This "statement for the record" is being submitted on behalf of HealthSouth Corporation ("HealthSouth") in connection with the House Ways and Means Health Subcommittee's Hearing on June 14, "Proposals to Reform Medicare Post-Acute Care ("PAC") Payments," that included testimony from Jonathan Blum, Deputy Administrator and Director, Center of Medicare, Centers for Medicare and Medicaid Services ("CMS") and Mark Miller, Executive Director, Medicare Payment Advisory Commission ("MedPAC"). HealthSouth operates 103 freestanding rehabilitation hospitals (also known as inpatient rehabilitation facilities, or "IRFs") in 28 states and Puerto Rico and employs approximately 23,000 people. As the largest provider of rehabilitation hospital care and services in the United States, we welcome the opportunity to work closely with Congress to find appropriate PAC reforms that can both improve care for our patients and extend the viability of the Medicare program.

In the coming weeks, HealthSouth plans to submit a more comprehensive and detailed letter on a number of PAC issues in response to the House Ways and Means and Senate Finance Committees' request for stakeholder input on PAC reform, pursuant to the "Dear Stakeholder" letter dated June 19, 2013. However, we wanted to take the opportunity to briefly address and provide additional clarification on several specific issues that arose out of the Subcommittee's June 14 hearing relating to the following issues: **I)** the 60% Rule; **II)** differences between IRFs and SNFs; **III)** IRF spending; and, **IV)** Medicare payments for IRF services compared to SNF services. These issues are discussed in more detail below.

I. 60% Rule

(A) "60 Percent Rule" Is a "Clunky" and "Crude" Policy, According to CMS and MedPAC

As the Subcommittee is aware, President Obama has included a proposal to revisit the so-called "60% Rule" by elevating the compliance threshold percentage from its current level of 60%, to 75%. HealthSouth agrees with Mr. Blum when he testified that "over the long term we need to move away from these more crude and clunky measures like…[the] 75-percent [Rule]." We also agree with Mr. Miller's testimony indicating that this policy appears to have little analytical or clinical rationale behind it, when he said that "…whether it's 60 percent or 75 percent, I don't think there's a lot of science in that."[1]

The 60% Rule was established in the mid-1980's to distinguish IRFs from general acute care hospitals; the original threshold percentage was 75%. The Rule stated that to be considered an IRF for Medicare reimbursement purposes, 75% of an IRF's patients would have to have one of 10 medical conditions (the Rule is now comprised of 13 conditions, often referred to as "CMS 13" or "qualifying conditions"). Like general acute care hospitals, rehabilitation hospitals previously were paid on a "cost-plus" basis. When Congress established prospective payment for general acute care hospitals in the early 1980's it recognized that the diagnosis related group, or "DRG"-based system would not be appropriate for IRFs, due to different cost structures associated with IRFs' clinical, rehabilitation, medical, and nursing programs as well as longer length of stays for IRF patients. Thus, Congress authorized the Secretary to define IRFs to distinguish them from acute hospitals and allow them to continue to be paid on a "cost-plus" reimbursement system. The 75% Rule was developed by the Secretary for this purpose. When IRFs moved to prospective payment ("IRF-PPS") in 2002, the Rule was still maintained despite the fact that cost-based reimbursement ceased.

The Rule's "qualifying conditions" have been identified as those that "typically require" the care and services of a rehabilitation hospital.[2] The Rule has nothing to do, per se, with Medicare's "reasonable and necessary" standard for coverage[3]–each case

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[1] In an appearance before the Health Subcommittee earlier this year, MedPAC Chairman Glenn Hackbarth similarly characterized the 60% Rule as "arbitrary."

[2] *See generally*, CMS's Final Rule implementing the 75% Rule, "Medicare Program; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility," 69 Fed. Reg. 25,752 (May 7, 2004); *see also*, 48 Fed. Reg. 39,752, 39,756 (Sept. 1, 1983).

[3] See generally, 74 Fed. Reg. 39,762, 39,789 (August 7, 2009) (CMS acknowledging substantive differences between Medicare's coverage principles and facility classification policies such as the 60% Rule).

treated in an IRF is subject to rigorous admission and coverage criteria that Medicare contractors use for probe audits, RAC reviews, and various other medical review-related activities that are intended to determine the "medical necessity" of claims submitted for Medicare reimbursement. We agree that the Rule's effect and impact is "arbitrary," "crude," and that it does not appear to have "a lot of science" behind it. In light of these characterizations, it would seem highly illogical to elevate the compliance threshold to 75%–thereby effectively intensifying and worsening the Rule's arbitrariness, crudeness and general lack of science.

(B) The 60% Rule's Impact and Congress's Response to It

The Rule's impact is straightforward: it imposes restrictions on the number and types of patients IRFs can admit–irrespective of what patients' physicians determine is in their best interest when considering their post-acute care rehabilitation needs–and because it forces IRFs to "manage to a number" it can have arbitrary results on patients' access to IRF services. It is not uncommon for an IRF to admit a "non-CMS 13" patient at a given point in time while being unable to admit the identical type of patient a relatively short period of time later, by virtue of the "manage to the number, stay-within-the-quota"-type mentality that the Rule imposes. Oftentimes when an IRF is unable to admit a patient due to the effects of the 60% Rule, he or she instead will be re-directed to a nursing home. Consequently, elevating the 60% Rule to a 75% Rule would impede patients' access to IRF services and force more of them into nursing homes. And, as we outline below, there are significant differences between the level of care offered in an inpatient rehabilitation hospital and those offered in a nursing home.

As the Subcommittee is aware, concerns with Rule's effects and its impact on Medicare beneficiary's access to rehabilitation hospital care led Congress in 2007 to specify in the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") that the compliance threshold would be permanently set at a level not to exceed 60 percent, in contrast to the 75 percent threshold slated to be imposed by CMS under a Final Rule it issued on May 7, 2004. Congress's decision to establish a permanent 60% Rule undoubtedly was influenced by bi-partisan, bi-cameral legislation introduced in 2007 that sought to establish such a Rule and that enjoyed 240 House co-sponsors (H.R.1459) and 61 Senate co-sponsors (S.543). 7 current Members of the Health Subcommittee co-sponsored that legislation, as did 7 other current members of the full Ways and Means Committee. The legislation was introduced by 2 former members of the Ways and Means Committee, Representatives Kenny Hulshof (R-MO) and John Tanner (D-TN).

Establishing a "permanent" 60% Rule was a policy choice that involved a "cost." The 60% Rule was "paid for" by the elimination of IRFs' market basket update for a year-and-a-half (from April 1, 2008 through September 30, 2009), which produced a budgetary savings to Medicare of $4 billion for the 2008-2017 budget window.

Ironically, were Congress to reinstate the 75% Rule it would be an effective "double-whammy" for IRFs and patients requiring our services, as there surely would not be a restoration of the cuts imposed that were used both to offset the costs of the permanent 60% Rule and help pay for 2008's "doc fix."

(C) Revisiting The 60% Rule Is Not Reform—But Changing The Way Medicare Pays for "Outliers" Under the IRF PPS Would Be

Reducing patients' access to IRF services by re-directing them into nursing homes is not "reform." Concerns with how Medicare pays nursing homes for therapy and rehabilitation services have been well-documented by CMS, MedPAC[4], and HHS-OIG.[5] CMS has acknowledged that "shifting patients from the IRF setting to a SNF setting is not necessarily more beneficial to the patient or the Medicare Trust Fund."[6] We are aware of nothing which would suggest that shifting more Medicare beneficiaries out of IRFs and into nursing homes would result in better care and outcomes for them notwithstanding that that is, effectively, the ultimate upshot of elevating the 60% Rule to 75%. We believe, respectfully, that there are better, more thoughtful and sound ways to achieve $1 billion in savings.

We wish to reiterate and emphasize with the Subcommittee that in expressing our respectful objections to the prospect of re-visiting the 60% Rule, we do not do so without acknowledging our understanding of the very real challenges facing Congress in its quest to ensure that Medicare is paying providers more accurately and with an eye toward encouraging efficient, cost-effective care that achieves high-quality outcomes for patients and to put the Medicare Trust Fund in a more stable fiscal position. It is with this understanding that we have put forth what we believe is a credible policy alternative instead of a more restrictive 60% Rule, that if adopted could potentially achieve a comparable range of budgetary savings that we believe merits this Subcommittee's and Congress's careful attention and consideration–reforming the so-called "outlier payment" policy under the IRF PPS.

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[4] *See, e.g.*, MedPAC, "Report to the Congress: Medicare Payment Policy," Chap. 7, pg. 193 (March 2012) (MedPAC recommending that SNF PPS be rebased in 2013 to "redistribute payments away from intensive therapy care that is unrelated to patient care needs…").

[5] *See, e.g.*, HHS-OIG Podcast describing report #OEI-02-09-002000 (relating to therapy payments under the SNF PPS having a "huge vulnerability" because providers have incentives to "bill for more therapy than the patient may need"), accessible on-line at: https://oig.hhs.gov/newsroom/podcasts/reports.asp#snf

[6] 76 Fed. Reg. 48,486, 48,499 (August 11, 2011).

Our analysis of the most recent outlier data available from CMS's IRF PPS Rate – Setting file for the FY 2014 Proposed Rule[7] reveals that the IRF-PPS made "outlier" payments totaling just under $214 million. Approximately 55% of these $214 million in outlier payments ($117.28 million) went to 113 of the 1,132 IRFs listed on the Rate-Setting file. Moreover, 226 IRFs received "outlier" payments under the IRF-PPS ranging from 8% to 57% of their *total Medicare payments*, with such payments representing over 60% (nearly $132 million) of all "outlier" payments. We believe that many of these payments are not going toward the intended policy purpose of providing additional payments to cover the unanticipated costs of random draws of particularly complex or ill patients but are instead attributable to inadequate cost management that leads to inefficient care.

To the extent Congress may determine this year that the IRF-PPS will be impacted as part of the "doc fix" or other similar measures, we believe rather than pursuing a policy that would place a burden on beneficiaries–which in the case of ratcheting the 60% Rule up to a 75% Rule would diminish their access to IRF services–that it should instead challenge IRFs to provide care and services more efficiently by more effective cost management, both of which could be accomplished through reducing the amount of "outlier" payments made under the IRF-PPS. This reduction could be achieved through several potential policy options, such as lowering CMS's withhold percentage under the IRF-PPS outlier policy below the current 3% rate, or placing a limitation on the amount of outlier payments that an IRF can receive as a percentage of its total Medicare payments. We believe that "reform" within the IRF-PPS should not focus on shifting more patients to nursing homes and diminishing their access to IRF services. Instead, the focus should be on the IRF-PPS outlier payment policy to encourage more effective cost management and more cost-efficient care. We respectfully urge the Subcommittee to continue examining this area of IRF payment policy in lieu of re-visiting the 60% Rule as it continues its deliberations on PAC reform and "doc fix" offset options throughout the year.

II. IRFs and SNFs Perform Fundamentally Different Services

There is a common misperception, highlighted by several comments and exchanges of dialogue and discussion during the hearing, as well as in the written testimony of the witnesses, suggesting that IRFs receive higher payments than skilled nursing facilities ("SNFs") for providing essentially the same care. With all due respect to the proponents of these types of statements, they are simply not accurate.

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[7] Accessible by scrolling down to "FY 2014 Data Files" at the following link on the CMS Website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html

Rehabilitation services provided in an IRF differ substantially from rehabilitation care provided in SNFs in several meaningful ways. Such differences include:

- **Medical Leadership by/from Rehabilitation Physicians:** All IRF patients are required to be managed by medical directors with specialized training in medical management of inpatients requiring rehabilitation. IRF patients must be approved for admission by rehabilitation physicians prior to admission, and within 24 hours of being admitted a rehabilitation physician must conduct a post-admission evaluation documenting the patient's admission status. These process and documentation-specific steps must be accompanied by ample clinical and medical detail of the patient's history, condition, and medical and rehabilitation needs in the medical record justifying why he/she needs to be seen "in person" at least 3 times per week by a rehabilitation physician (and of course, those "in person" visits must actually occur). In addition to having a documented need for requiring physician supervision by a rehabilitation physician, IRF patients must also have an overall plan of care developed by a rehabilitation physician documented in his/her medical record. SNFs have no similar requirements for the medical management and oversight of their patients, including medical rehabilitation led by a rehabilitation physician; it is entirely possible for SNF patients to go many days if not weeks without ever seeing a physician–much less a physician with specialized skill and training in rehabilitative medicine.

- **Intensive Therapy Requirements; Specified Admission Criteria:** With few exceptions, all IRF patients must have a well-documented need for, and actually receive, therapy that is provided on a multi-disciplinary basis (which must include either physical therapy or occupational therapy) for at least 3 hours per day, 5 days per week (or otherwise receive 15 hours of therapy per week). Nursing homes have no similar requirement.

- 24 Hour/7 Day a Week Nursing Care: IRFs are licensed as hospitals and are required to provide patients with around-the-clock nursing care provided by Registered Nurses. Many of these Registered Nurses have special certification as a Certified Rehabilitation Registered Nurse. Nursing homes have no such requirement.

IRFs provide a distinct, physician-driven level of care and are required to meet hospital conditions of participation and other policies and regulations developed and implemented specifically for an IRF level of care and the intensity of services we provide. These policies and regulations involve rigorous admission and coverage criteria that require IRFs to carefully evaluate whether a patient needs IRF services. That evaluation is based at its core on the judgment and expertise of physicians skilled and

trained in rehabilitation medicine, and their judgment should not be subordinated to payment policies that make no distinctions between the services and quality of care outcomes achieved in IRFs and SNFs. There are significant differences between IRFs and SNFs, and Medicare's payment policies should recognize them.

III. IRF Spending is Not the Growth Problem in Medicare PAC Spending

Many of the IRF-specific proposals discussed at the hearing are based on the inaccurate premise that Medicare spending for IRF services is growing rapidly. Indeed there was a certain "tone" to the hearing to the effect that Medicare expenditures for PAC services are growing at a rapid clip and such growth is occurring across the board in all PAC payment systems. Despite significant Medicare spending increases for other PAC providers (particularly SNFs and Home Health), Medicare's IRF expenditures have been relatively stable since 2004 and, since 2007 have consistently represented less than 1.5% of overall Medicare expenditures. Expenditure growth for SNF and Home Health accounted for 88% of total PAC expenditure growth between 2007 and 2011 while IRF spending growth during that period accounted for only 5% of total PAC expenditure growth, as demonstrated in the following table:

	2007	2011	Change	% of Spending Increase
IRF	$5,264,800,000	$5,884,064,000	$619,264,000	5%
LTACH	$4,332,000,000	$5,229,000,000	$897,000,000	7%
HH	$15,362,000,000	$18,437,000,000	$3,075,000,000	25%
SNF	$21,953,000,000	$29,751,000,000	$7,798,000,000	63%
Total PAC[8]	$46,911,800,000	$59,301,064,000	$12,389,264,000	100%

According to CMS's most current data, higher PAC costs, on a per capita basis, essentially point to seven states where PAC spending is significantly higher than the national average: Louisiana, Texas, Mississippi, Florida, Oklahoma, Massachusetts, and Illinois.[9] Yet, higher per capita PAC expenditures in each of these states are driven by non-IRF PAC sectors. In Texas, for instance, high PAC expenditures are almost solely associated with high utilization of Long-Term Acute Care Hospitals, high utilization of

[8] All data in table are "standardized."

[9] Data derived from Medicare's "Geographic Public Use File" (accessible on CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html).

Home Health, and high per-user Home Health expenditures.[10] In Florida, higher PAC expenditures are driven by high utilization and costs for both Home Health and SNF services.[11] Despite claims made by proponents of certain IRF-reform proposals, although growth in Medicare PAC expenditures has occurred, it has not been fueled by significant IRF expenditure growth.

IV. Cost Differences Between IRFs and SNFs are Not "Quite Significant"

Several comments during the hearing suggested that cost differences between IRFs and SNFs are "quite significant"–however, based on CMS data this is not necessarily the case. The cost difference between IRFs and SNFs when evaluating the national average cost per case (standardized) in 2011 was somewhat comparable: $16,794 for SNFs and $18,131 for IRFs; and, that year nearly 28 percent of Medicare SNF users had an average cost per case *that was more than* Medicare's national average cost per case for IRF services. Thus, basing any PAC reform proposal on the assumption that cost differences between IRFs and SNF are "quite significant" would not be accurate.

HealthSouth appreciates the opportunity to share this statement for the record with the Subcommittee. We appreciate the Subcommittee's leadership and look forward to working with your staff and you in the months and years ahead to develop sensible and sound policies that can improve our PAC payment systems. We look forward to submitting a more comprehensive comment letter on PAC reform in the coming weeks. Please do not hesitate to contact me on (202) 239-3466 or via email at justin.hunter@healthsouth.com if you have any questions about this statement for the record.

Sincerely yours,

Justin R. Hunter
Senior Vice President
Public Policy, Legisaltion, and Regulations
HealthSouth Corporation

[10] *Id.*
[11] *Id.*

Supplemental Contact Sheet

This supplemental contact sheet is being submitted in connection with a "statement for the record" submitted to the Ways and Means Health Subcommittee on June 28, 2013 in connection with the hearing entitled, "Proposals to Reform Medicare Post-Acute Care Payments," held on June 14, 2013.

The statement is being submitted by Justin Hunter on behalf of HealthSouth Corporation (based in Birmingham, Alabama). Mr. Hunter is HealthSouth's senior vice president of pubic policy, legislation, and regulations, and he is based in Washington, D.C. His contact information is as follows:

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National Association for Home Care & Hospice, NAHC

STATEMENT SUBMITTED BY

ANDREA DEVOTI, CHAIR, NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE BOARD OF DIRECTORS; PRESIDENT AND CEO OF NEIGHBORHOOD HEALTH AGENCIES, WEST CHESTER, PENNSYLVANIA

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

JUNE 14, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Ways and Means Subcommittee on Health reviews proposals to reform Medicare post-acute care payments, NAHC appreciates this opportunity to provide our views. We agree with the Chairman and Ranking Member that we should find the right reforms in post-acute care that can both improve care for today's seniors and extend the fiscal viability of the program well into the future.

Many studies have found that home health care can prevent expensive hospitalizations and nursing home stays while providing cost effective care in the home setting that people prefer, keeping families together and preserving individual dignity. Our members are participating in the new Affordable Care Act (ACA) innovations with enthusiasm and good ideas, seeking greater efficiency while providing high quality services in the home. We pledge to continue to be good partners in finding solutions.

Some proposals have suggested cutting payments to home health care providers and bundling payments to home health providers with payments to other Medicare providers. We have grave

concerns about the impact of further cuts to home health care payments on access to care and want to ensure that efforts to bundle payments to post-acute care providers recognize the central role that home health should play. We would like to make the following recommendations.

ENSURE MEDICARE HOME HEALTH PAYMENTS ARE ADEQUATE TO PROTECT ACCESS TO CARE

Since 2009, when it was a $17 billion industry, the Medicare home health benefit has been cut by a disproportionate $77 billion over 10 years. The cumulative effect of these cuts has been to limit access to patients, pushing thousands of providers to the point of bankruptcy.

With the 78 million baby boomer generation reaching their 65th birthday at the rate of 10,000 per day for the next 19 years, the need for home health services will only increase. Home health keeps families together and is overwhelmingly what patients prefer. It is far more cost effective for Medicare than institutional options. Below are the details of these massive cuts:

- Congress included $39.7 billion in home health payment cuts under the ACA through 2019. It reduced the home health inflation update one percentage point for 2011, 2012, and 2013, mandated rebasing of home health payment rates beginning in 2014 with a 4-year phase-in, and imposed a productivity adjustment in the inflation update beginning in 2015 that will reduce the inflation update by an estimated 1 percentage point each year. While home health represents less than 6 percent of Medicare spending it took a disproportionate 10 percent in Medicare payment cuts used to pay for the ACA.
- The Centers for Medicare and Medicaid Services (CMS) issued rules that cut home health payment rates by 2.75 percent in 2008, 2.75 percent in 2009, 2.75 percent in 2010, 3.79 percent in 2011, 3.79 in 2012, and 1.32 in 2013 — for total reductions of over 16 percent which was in addition to the ACA rate cuts. The Congressional Budget Office (CBO) recently increased the projected impact of the cuts to more than $32 billion.
- As a result of sequestration, home health patients and providers will take an additional 2 percent cut reducing payments over the next 10 years by $6 billion dollars.

The President's FY 2014 budget proposal to cut payments another 1.1 percent over the next ten years would further threaten access to home health care. Moreover, it ignores rebasing scheduled to begin next year, which will likely cut home health rates to the bone. More payment cuts on top of rebasing would devastate access to care.

Congress must closely monitor the implementation of the rate rebasing by CMS. Congress should ensure that CMS properly considers cost trends in home health agencies and the imposition of new costs not included in cost report databases. All types of home health agencies should be included in any CMS analysis of costs. Further, Congress should ensure that the rate rebasing include all usual and customary business costs consistent with standards under the Internal Revenue Code, including telehealth services, all disciplines of caregivers, and usual business operating expenses along with needs for operating capital and operating margins. We will provide the committee with a white paper to explain rebasing and our recommendations in more detail.

Congress should also restrict the ability of CMS to modify payment rates and revise the case-mix adjustment system. These restrictions should require that no adjustments occur without adequate advance notice of at least 12 months and that CMS develop criteria for application of its case-mix adjustment correction authority through public rulemaking. The procedural standards set out in the Home Health Care Access Protection Act should be enacted and applied prospectively to any further coding weight adjustments.

In summary, the Medicare home care benefit which was $17 billion in 2009 has been cut by a projected $77 billion over the following ten years. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending is less today than in 1997. As a result of these cuts 46.8 percent of all Medicare participating agencies are projected to be under water in 2014 — that is, paid less than their costs by Medicare.

We project that with rebasing and further cuts in home health payments over the next ten years as proposed in the President's budget, the percentage of agencies that will be underwater will be nearly 65 percent in 2023. A breakdown of these projections by state is provided in an Appendix below. The risk is particularly high in some states represented on this Subcommittee—Texas, Washington, California, Illinois, Nebraska, Oregon, and Wisconsin—where about 70 percent or more of home health agencies are projected to have negative margins in 2023.

We use the same methodology that MedPAC uses, except that we do not exclude hospital-based agencies as MedPAC does. We think this is a continuing flaw in MedPAC's analysis of agency margins. It should also be noted that MedPAC uses antiquated home health cost reports in computing margins that do not include all agency costs, such as the costs of telehomecare. Although we think this is a significant flaw, we use the same methodology in our analysis. Consequently, we believe our analysis is a conservative estimate of the impact of payment cuts.

In order to protect access to home health care, Congress should resist making additional cuts in home health care payments for any reason, including postponement/elimination of scheduled cuts in Medicare physician fees or for deficit reduction.

ENSURE HOME HEALTH CARE PARTICIPATION IN TRANSITIONS IN CARE, ACCOUNTABLE CARE ORGANIZATIONS, CHRONIC CARE MANAGEMENT, HEALTH INFORMATION EXCHANGES, AND OTHER HEALTH CARE DELIVERY REFORMS.

The ACA includes significant health care delivery system reforms in addition to expansion of Medicaid eligibility, health insurance reforms, and Medicare payment changes. These health care delivery reforms have the potential to radically alter how and where patients receive care. Overall, these reforms shift the focus of care from inpatient services and institutional care to the community setting. Further, these reforms provide a combination of incentives to clinically maintain patients in their own homes and penalties for excessive re-hospitalizations of patients. Importantly, these reforms also focus on individuals with chronic illnesses, providing support for health care that prevents acute exacerbations of their conditions and avoids both initial and repeat hospitalizations.

The ACA includes, among other health care reforms, new benefits, payment changes, pilot programs and demonstration projects such as Accountable Care Organizations, Transitions in Care penalties for re-hospitalizations, a Community Care Management benefit, and trials of integrated and bundled payment for post-acute care.

Home care offers an opportunity for these new programs to work at their highest potential for efficiency and effectiveness of care. Home care brings decades of experience in managing chronically ill individuals with a community-based care approach, limiting the need for inpatient care and creating a comprehensive alternative to most institutional care.

If these health care delivery reforms are to fully succeed, CMS must recognize the value of home health care as part of the solution to out-of-control health care spending, particularly for patients with chronic illnesses. CMS should take all possible steps to ensure that any pilot programs or demonstration projects include home care as active participants and, where appropriate, as the qualified, controlling entity to manage post-acute care and patients with chronic illnesses.

Congressional reforms of the health care delivery system recognize home care as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in the ACA to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.

With regard to proposals to bundle payments to post-acute care providers, we are encouraged that CMS is testing a post acute care bundling program where all provider payments are held and administered by home health agencies. This would deter unnecessary re-hospitalizations, thus reducing administrative burden and cost, as well as increase the quality and availability of home health care. This approach is comparable to the tried and tested Medicare hospice program where payment is bundled to a community-based hospice program where hospitalization is the exception rather than standard practice.

The Fostering Independence through Technology (FITT) Act and the Home Health Care Planning Improvement (HHCPI) Act are two bills that would greatly enhance the cost saving potential of home health care. The FITT Act would provide payment incentives for the use of telehomecare technologies. The HHCPI would allow nurse practitioners and physician assistants to certify Medicare eligibility for home health care. Currently these health professionals may put a beneficiary in a skilled nursing facility, but not in more cost effective home health care.

Community-based care is a valuable, but under-utilized health care asset with respect to efforts to reduce hospitalizations and re-hospitalizations. Further, community-based chronic care management has long been provided effectively by home health agencies. However, the antiquated structure of Medicare benefits has prevented its application at full capacity. The

reforms in the ACA present the opportunity to build a new care delivery model that is not handicapped by this out-of-date structure and to overcome longstanding weaknesses in health care delivery.

APPENDIX

PERCENTAGE OF HOME HEALTH AGENCIES AT RISK OF CLOSURE DUE TO MEDICARE PAYMENTS LESS THAN THE COST OF CARE		
Potential risks from a combination of CMS regulatory cuts, cuts enacted under the Affordable Care Act, 2% Medicare Sequestration, and an additional 1.1 percent cut in Market Basket Updates over the next ten years		
State/Territory	**Percent of Agencies – 2014**	**Percent of Agencies – 2023**
National	**46.8%**	**64.86%**
Alabama	29.6%	52.17%
Alaska	75.0%	91.67%
Arizona	46.7%	58.89%
Arkansas	41.2%	58.82%
California	57.4%	74.00%
Colorado	38.1%	46.67%
Connecticut	25.7%	34.29%
Delaware	40.0%	66.67%
District of Columbia	40.0%	46.67%
Florida	45.0%	64.53%
Georgia	32.3%	42.71%
Guam	50.0%	100.00%
Hawaii	77.8%	100.00%
Idaho	56.4%	74.36%
Illinois	50.8%	70.48%
Indiana	57.2%	73.99%
Iowa	52.1%	73.97%
Kansas	49.5%	61.68%
Kentucky	40.2%	56.70%
Louisiana	26.2%	46.15%
Maine	40.0%	76.00%
Maryland	37.2%	76.74%
Massachusetts	32.2%	55.65%
Michigan	47.0%	69.35%
Minnesota	45.1%	54.95%
Mississippi	8.1%	40.54%
Missouri	52.9%	70.97%
Montana	72.4%	79.31%
Nebraska	58.7%	69.84%
Nevada	54.4%	79.35%

New Hampshire	31.0%	62.07%
New Jersey	40.5%	66.67%
New Mexico	54.4%	68.42%
New York	74.0%	86.55%
North Carolina	30.5%	48.05%
North Dakota	80.0%	80.00%
Ohio	33.6%	45.98%
Oklahoma	47.3%	65.67%
Oregon	78.3	86.96%
Pennsylvania	34.9%	52.38%
Puerto Rico	51.4%	71.43%
Rhode Island	19.1%	23.81%
South Carolina	36.0%	60.00%
South Dakota	45.2%	61.29%
Tennessee	22.9%	41.22%
Texas	50.7%	69.12%
Utah	36.4%	62.34%
Vermont	25.0%	58.33%
Virgin Islands	50.0%	50.00%
Virginia	39.7%	58.05%
Washington	62.8%	76.47%
West Virginia	37.0%	52.17%
Wisconsin	64.7%	72.94%
Wyoming	70.4%	81.48%

The Nebraska Association of Home & Community Health Agencies, NAHCHA

The Nebraska Association of Home & Community Health Agencies (NAHCHA) represents a majority of Nebraska's home health providers, who serve more than 12,000 home health clients in our state. That number will continue to grow as the Baby Boomers age and consumers wish to stay in their homes. NAHCHA wishes to submit written comments for the June 13, 2013 House Ways and Means Subcommittee on Health hearing, respectfully requesting that the subcommittee carefully reviews the impact and results of further cuts to home health services for Medicare beneficiaries.

Home health beneficiaries are the aged and disabled with limited income. Protections must remain for them to continue to receive high-quality, affordable healthcare in the comfort and safety of their homes. NAHCHA members are innovative in delivering skilled healthcare services in the home, in teaching patients and family caregivers how to manage chronic diseases and other conditions, in teaching patients how to improve their wellness, and ensuring that patients remain out of the hospital. NAHCHA worked with a state senator this spring to introduce an interim resolution study through the state legislature that examines new ways to pay for and deliver high-quality in-home services to Nebraskans in underserved areas of our state, in order to reduce overall health care expenditures. We have proposed pilot projects in communities with populations of less than 500 people, in order to demonstrate how providing high-quality care to Nebraskans in their homes helps meet their healthcare needs in an affordable manner. We invite you to contact us to learn more about this study, and to learn more about how home health clinicians (nurses, therapists) are working every day to deliver cost-effective and efficient healthcare services in the home.

Medicare spending on home health services has already been cut by $77 billion over the next 10 years. As a result of these cuts, 50% of Medicare participating agencies will be paid less than their costs by Medicare.

- Congress included $39.7 billion in home health payment cuts under the Patient Protection and Affordable Care Act (PPACA) through 2019. It reduced the home health inflation update one percentage point for 2011, 2012, and 2013, mandated rebasing of home health payment rates beginning in 2014 with a 4-year phase-in, and imposed a productivity adjustment in the inflation update beginning in 2015 that will reduce the inflation update by an estimated 1 percentage point each year. While home health represents about 5 percent of Medicare spending, it took a disproportionate 10 percent share of Medicare payment cuts used to pay for the Patient Protection and Affordable Care Act.
- The Centers for Medicare and Medicaid Services (CMS) issued rules that cut home health payment rates by 2.75 percent in 2008, 2.75 percent in 2009, 2.75 percent in 2010, 3.79 percent in 2011, 3.79 percent in 2012, and 1.32 percent in 2013 — for total reductions of over 16 percent which was in addition to the PPACA rate cuts.
- The Congressional Budget Office (CBO) recently revised its projection on Medicare home health spending, reducing it by over $32 billion to reflect the impact of legislative and regulatory cuts along with other factors.

- As a result of sequestration, Congress's agreement in August 2011 reduced the federal budget deficit. Home health providers are taking an additional 2 percent cut in payments in 2013, reducing projected home health spending by $6 billion over 10 years.

Further cuts and copays will send home health patients to more costly care settings. Home health provides cost-effective care, preferred by patients. Our member agencies – and other agencies around the United States – improve patient outcomes and attribute to improved health and wellness. Allow Americans to continue to choose home.

The Visiting Nurse Associations of America, VNAA

VNAA Advancing Nonprofit Home Healthcare and Hospice

Committee on Ways and Means

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

June 14, 2013

Statement for the Record

The Visiting Nurse Associations of America (VNAA) thanks the Committee for this opportunity to submit a statement for the record for the hearing on the "President's and Other Bipartisan Proposals to Reform Medicare Post-Acute Care Payments." VNAA remains very concerned about proposals that would impose short-sighted payment cuts in the Medicare program. VNAA continues to support efforts to strengthen the role that post-acute care can play in improving quality and reducing health care costs across the health care system.

Home Health Overview
VNAA represents community-based nonprofit home health and hospice providers throughout the United States. Our members care for patients with serious and often chronic conditions by providing a full array of healthcare services along with care coordination, management and prevention. Our members are a vital link between homebound patients, their physicians and acute care settings. VNAA members serve all patients without regard to their ability to pay or the severity of their illness, with a particular focus on ensuring access for vulnerable patients.

Requirements for the home health benefit are clearly defined and stringent. Only a physician may order home health after a face-to-face encounter with the patient. The patient must be unable to leave home without a "considerable and taxing effort" and a skilled care such as nursing or therapy must be required. Care must be intermittent. An "episode of care" lasts 60 days but can be renewed if specific conditions are met.

According to the most recent statistics, the Medicare Payment Advisory Commission (MedPAC) reports that only 3.4 million or 9.5% of traditional Medicare beneficiaries used home health in 2011. Beneficiaries who have multiple chronic conditions account for a greater share of Medicare spending than those with a single chronic condition or none. Of the patients who received home health in 2011, 86% have 3 or more chronic conditions.

Home health represents only a very small percentage of Medicare expenditures and helps to reduce costly inpatient care. According to MedPAC, home health was only 4% of overall Medicare spending in 2011 compared to 24% for hospital inpatient and 6% for skilled nursing facilities.

Policy Recommendations
VNAA supports the goal of placing the Medicare program on sound fiscal footing and takes seriously the policy recommendations in the President's budget to encourage efficient post-acute care and related recommendations by MedPAC and other organizations. However, our members strongly believe that improvements in the Medicare program should be made through encouraging participation in more collaborative delivery, rather than through across-the-board payment reductions to providers or the imposition of co-payments for patients.

For this reason, VNAA has strongly supported and been actively involved in efforts to decrease hospital readmissions, better coordinate care through participation in new delivery models (Accountable Care Organizations, Independence at Home projects bundling programs) as well as increasing use of health information technology (HIT) to improve patient care.

The active involvement of VNAA's members in these new delivery models is driving real care improvements on the ground. These improvements include working more closely with hospitals, doctors and nursing homes to improve patients' transitions from institution to home and ensuring patients have the supports they need to keep them out of the hospital. As part of this effort, VNAA member agencies have placed an increasing focus on medication reconciliation efforts and on ensuring all providers on the health care team are appropriately sharing pertinent patient information, such as discharge summaries, through the use of HIT. These efforts are resulting in more informed decisions about patient care and improved care coordination. Over time, we strongly believe these activities will result in better quality outcomes and reduced costs to the Medicare program.

VNAA urges Congress to work with post-acute providers to determine if there are barriers in the current system that discourage providers from participating in or being successful in these new delivery models. For example, home health and hospice providers do not receive federal incentive payments for their investment in HIT which makes it difficult for them to assist physician and hospitals in more effective management of patient care.

VNAA would be very interested in working with Congressional leaders to identify challenges and opportunities to realize the full value of high-quality cost effective care at home. VNAA believes that continuing on the path toward delivery system reform is the appropriate way to place the Medicare program on stronger fiscal ground, rather than focusing on policies that simply reduce payments to providers or implement co-payments for beneficiaries.

VNAA further urges Congressional leaders ensure the Medicare home health prospective payment system adequately covers the costs of treating vulnerable patients. Recently, VNAA completed a study focused on vulnerable patients who received home health. Results of the "Vulnerable Patient Study" demonstrate that imposing additional out-of-pocket cost requirements, such as establishing a home health copay, could

reduce access to care for the most vulnerable patients. The study also raised concerns about whether home health agencies are paid appropriately for treating certain high-risk patients.

Specifically, the study found that Medicare home health episodes for patients with the following characteristics tended to have significantly lower reimbursement compared to cost:

- Communities with lower median household incomes
- Poorly-controlled chronic conditions (e.g. hypertension, diabetes, peripheral vascular disease)
- Intensive treatments including respiratory, intravenous, infusion therapy, and parenteral nutrition
- Clinically complex post-acute and community admissions
- Serious or frail overall status
- Problematic (higher stage) pressure ulcers
- Urinary and bowel incontinence
- No caregiver assistance for activities of daily living (eating, mobility, hygiene) as well as medication administration or medical procedures such as wound cleaning

Given the findings of this important study, VNAA urges that any changes to the Medicare home health payment system, including rebasing, must take into consideration the costs of providing care to patients with these characteristics.

VNAA appreciates this opportunity to provide input into the Committee's considerations on post-acute reform proposals and looks forward to continuing to work with you on efforts to strengthen the Medicare program. If you have any questions please contact Kathleen Sheehan, Vice President of Public Policy, VNAA at 202-384-1456 or ksheehan@vnaa.org.

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