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ONE HUNDRED FOURTEENTH CONGRESS
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April 14, 2015
MEMORANDUM

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Commerce on Energy and Commerce Democratic Staff

Re: Subcommittee on Health Hearing on "Medicare Post-Acute Care Delivery and Options to Improve It"

On Thursday, April 16, 2015, at 10:15 a.m. in 2322 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled "Medicare Post-Acute Care Delivery and Options to Improve It." The hearing will examine H.R. 1458, the Bundling and Coordinating Post-Acute Care Act (BACPAC) of 2015, introduced by Reps. David McKinley (R-WV) and Jerry McNerney (D-CA).

I. BACKGROUND

Post-Acute Care (PAC) refers to recuperation and rehabilitation services for those recovering from an acute hospital stay. Medicare covers PAC in four settings: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health agencies (HHAs). Medicare Part A covers all four PAC services, and Part B covers some home health.

According to MedPAC, in 2013, 42 % of Medicare fee-for-service beneficiaries that were discharged from an acute care hospital went on to acquire PAC: 20 % to SNFs, 4 % to IRFs, 1 % to LTCHs, and 17 % to HHAs.[1] Medicare spending on PAC services reached $59 billion (or 9.6 million PAC encounters) in 2013. Medicare PAC spending doubled between 2001 and 2012.[2]

Patients may use more than one type of PAC after a hospitalization (e.g., discharge first to a SNF, then to home health). Below are descriptions of each setting.

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[1] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* (Mar. 2015).

[2] *Id.*

A. Inpatient Rehabilitation Facilities

IRFs provide rehabilitation care (e.g., physical, occupational, speech-language pathology) to severely ill patients who are expected to benefit from intensive rehabilitation therapy (at least 3 hours/day, 5 days/week) in the hospital environment. Patients may be admitted to an IRF directly from the community. At least 60 % of patients in IRFs must have at least one of 13 specific medical diagnoses (e.g., stroke, spinal cord injury, hip fracture, brain injury, neurological disorders, and burns).

In 2013, IRFs treated about 338,000 Medicare fee-for-service (FFS) beneficiaries and received payments of $6.8 billion. The 2013 aggregate Medicare margin was 11.4 %, with margins of 24.1 % at freestanding IRFs.[3]

B. Long-Term Care Hospitals

LTCHs furnish care to beneficiaries who need hospital-level care for relatively extended periods, including patients with chronic critical illnesses that often result in profound debilitation and/or respiratory failure. Many LTCH patients require prolonged mechanical ventilation. While most chronically critically ill patients are treated in acute care hospitals, a growing number are treated in LTCHs. To qualify as an LTCH, the facility average length of stay of Medicare patients must be greater than 25 days.

The geographic distribution of LTCHs is very uneven. Some regions lack LTCHs and medically complex patients receive appropriate care in other facilities (e.g., acute care hospitals and SNFs), raising questions about the value-add of LTCHs. Other regions have many LTCHs, raising concerns that oversupply may be leading to unnecessary use of costly LTCH services by less severely ill patients.

Policymakers have long had concerns that inpatient hospitals may prematurely discharge patients to LTCHs (perhaps to LTCHs with which they have financial relationships), resulting in two payments by Medicare.

In 2013, Medicare spent $5.5 billion on LTCH services to 122,000 beneficiaries, an average of $40,000 per case. The aggregate Medicare margin was 6.6 % in 2011.[4]

C. Skilled Nursing Facilities

SNFs provide short-term residential skilled nursing and rehabilitation services to patients after a three-day hospitalization. Common conditions are post-hip/knee joint surgery, stroke, pneumonia, heart failure, and urinary tract infection. Approximately 20 % of all beneficiaries who were hospitalized in 2011 were discharged to a SNF. Most SNFs are certified as both a SNF and a nursing home. (Medicare does not cover nursing home care, per se. Such services, which are generally less-intensive, long-term custodial care, are covered by Medicaid, private

[3] *Id.*
[4] *Id.*

insurance or are paid directly by the patient.)

In 2013, nearly 15,000 SNFs provided Medicare-covered care to 1.7 million fee-for-service beneficiaries during 2.4 million SNF stays. Medicare spending for SNFs in 2013 was $28.8 billion, about 6 % of Medicare spending. The estimated 2013 aggregate Medicare margin for free-standing SNFs was 22% to 24 %, with margins consistently above 10 % for the last decade.

D. Home Health Agencies

HHAs provide services to beneficiaries who are homebound and need skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work in their home. Common patient diagnoses include diabetes, hypertension, heart failure, skin ulcers, and osteoarthritis.

Home health agencies provide services to the largest number of post-acute Medicare beneficiaries (3.5 million in 2013). Medicare spending for home health care has doubled since 2001, with $17.9 billion spent on home health services in 2013 (5 % of fee-for-service spending). The Medicare margin for free-standing home health agencies was 12.7 % in 2013 and averaged 17 % for the previous 10 years. Although home health agencies are widely distributed throughout the United States, the highest service use is in five states (FL, LA, MS, OK, TX). These states account for 35 % of all home health care episodes, despite accounting for only 17 % of beneficiaries. While much of this care may be legitimate, 25 counties from these states have unusually high utilization rates (88 home health episodes per 100 beneficiaries as compared to 13.7 episodes per 100 beneficiaries for all other states) raises questions of potential fraud/abuse.[5]

II. PAC POLICY CHALLENGES

The Medicare PAC systems face a number of policy challenges. There is substantial variation in quality of care, utilization patterns, and payment rates for comparable services provided to similar patients across different sites of care.

A. Lack of Placement Guidelines/Placement Decision Factors

There are no clear placement guidelines delineating which setting may be right for a particular patient or condition. The various settings may treat similar types of patients but have variations in their payment rates.

Further, Medicare allows PAC providers to determine which beneficiaries they will admit among those that were referred by hospitals. Instead of basing placement decisions on clinical appropriateness, often providers and patients will choose based on local practice patterns, availability of PAC, patient and family preference, and financial arrangements between a PAC provider and referring hospital. In addition, providers tend to operate in silos, which presents challenges for care transitions between settings and may fail to incentivize the types of behavior necessary to avoid preventable hospital readmissions.

[5] *Id.*

B. Lack of Uniform Assessment Information

There is not yet a common assessment tool in operation to help define the proper setting for patients and conditions. Congress passed the IMPACT Act (discussed further below) last year to address this problem. IMPACT requires PAC providers to report common data elements across settings, including patient assessments of function and mobility, and quality and resource use measures.

C. Medicare Margins

Many providers in this sector have high margins, which may indicate that Medicare reimbursement rates are too high. For-profit providers' margins are higher than those for nonprofit providers. MedPAC found that HHA and SNF margins have been above 10 % every year since 2001.[6] The influx of for-profit providers potentially points as well, to payment rates being too high.

In addition, payment systems may provide financial incentives for certain types of care that may not be medically necessary (e.g., physical therapy in the SNF setting has a reimbursement rate far higher than its cost) over other kinds of care. Meanwhile, quality of care has not considerably improved, raising questions about the value of Medicare's purchases.

D. Geographical Variation

Medicare spending for post-acute services varies greatly across the United States and is responsible for a large share in the overall variation in Medicare spending. Some regions have extremely high rates of PAC usage per beneficiary (e.g., home health in Texas) raising concerns about fraudulent behavior and questionable practice patterns. Other regions have extremely high numbers of a certain type of provider (e.g., LTCHs in Louisiana) that do not exist in other parts of the country, yet beneficiaries in those regions are able to access appropriate care in other settings, raising questions about the value-added by LTCHs.

III. RECENT PAC REFORMS

A. The Affordable Care Act (ACA)

The ACA included a number of reforms to PAC settings. As a result, Medicare is now testing and advancing many delivery system reforms for PAC. For example, the Centers for Medicare and Medicaid Services (CMS) is analyzing the concept of bundled payments, which could break down silos and encourage better coordinated and more efficient delivery of care. CMS is also starting to work towards value based purchasing, with pay-for-reporting and demonstration projects to test the concept. The ACA also required rebasing the Home Health Prospective Payment System (PPS), the method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount, 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

[6] *Id.*

increments with the adjustments fully implemented for 2017. In addition, the ACA 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.

B. The IMPACT Act

The IMPACT Act, passed in September 2014, was the result of a bipartisan, bicameral process resulting from a request for stakeholder input. A common theme across all the stakeholder responses was the need for a common post-acute assessment tool that works across all four Medicare PAC provider settings. The lack of comparable information across PAC settings undermines Congress' ability to determine whether patients treated in different settings are, in fact, receiving the same or similar treatments, or whether one PAC setting is more appropriate than another. Absent this information, it is difficult to move forward with PAC payment reforms, which could unintentionally result in payment incentives that push beneficiaries into inappropriate settings of care.

The IMPACT Act directs the Secretary to collect standardized patient assessment data across all four settings of post-acute care. This data will be used to facilitate care coordination and improve Medicare beneficiary outcomes among PAC and other providers. For more information, see the attached summary.

C. H.R. 2, The Medicare Access and Children's Health Insurance Program Reauthorization Act

In the permanent SGR repeal and replace legislation that recently passed the House and is now awaiting Senate action, Congress reduced the market basket update in 2018 to 1 % for LTCHs, SNFs, IRFs, and HHAs. Individual market baskets are produced for many of the Medicare payment systems to accurately measure the price changes facing each of these providers. They are then used to update payments to these providers. The Office of the Actuary (OACT), within CMS, is responsible for producing the CMS market baskets.

IV. POLICY PROPOSALS

In addition to the BACPAC Act, on which this hearing will focus, there are a variety of policy ideas to address the issues raised above, put forth by MedPAC, the President's FY16 Budget, and others. These ideas include: market basket cuts; rebasing of payments and modifications to payment formulas to address overpayments and correct financial incentives that reward certain types of care over others; value based purchasing to encourage quality improvements; readmissions programs to incentivize care that helps to avoid preventable hospital readmissions; bundled payments that encompass services across the array of PAC settings to encourage better cooperation between settings and improve care transitions; and site neutral payments to remove incentives to provide care at the highest reimbursed setting.

Some of these ideas are immediately viable and are realistic options for enactment this year. Others require more development or refinement and would be better informed by the ACA delivery system reform testing currently underway.

V. MEDPAC/PRESIDENT FY16 BUDGET RECOMMENDATIONS

A. Site Neutral Payments

MedPAC recommends implementing site-neutral payments for certain select conditions (to be determined by the Secretary) between SNFs and IRFs. For the select conditions, the majority of cases are treated in SNFs and the risk profiles of patients treated in IRFs and SNFs are similar, yet Medicare's payments made to IRFs are considerably higher than those made to SNFs. MedPAC compared the outcomes for patients treated in both settings and did not find consistent differences. For the selected conditions, the Commission recommends that the IRF base rate be set equal to the average SNF payment per discharge for each condition (additional payments that many IRFs receive are not changed by this policy). The policy should be implemented over three years. As part of the policy, IRFs should be relieved from the regulations governing the intensity and mix of services for the site-neutral conditions. This would result in Medicare Savings of between $1 and $5 billion over five years.[7]

Beneficiary groups are concerned that reducing requirements for IRFs so that they look like SNFs will jeopardize the availability of an important intensive level of care that is needed by many Medicare beneficiaries at a critical time in their recovery. They argue that Congress should wait to examine the standardized data generated by the IMPACT Act in 2018 before calling for site-neutral payments.

B. Bundling

MedPAC recommends that eventually Medicare pay for PAC using a single payment system that bases payments on patient characteristics, not the site of service. As required by the IMPACT Act, MedPAC is developing a prototype PPS to span the PAC settings using the uniform assessment data gathered as part of CMS's PAC payment demonstration. The law also requires PAC providers to submit patient assessment data using a uniform assessment tool beginning in 2018 and requires the Secretary of Health and Human Services (HHS) to recommend a uniform payment system for PAC based on two years of uniform patient assessment data. Thus, MedPAC believes a new PAC payment system is unlikely to be in place until 2023 at the earliest.

The President's FY2016 Budget also included a proposal to implement bundled payment for PAC providers beginning in 2020. Payments would be bundled for at least half of the total payments for post-acute care providers. Rates based on patient characteristics and other factors

[7] Medicare Payment Advisory Commission, Report to the Congress, Medicare Payment Policy (Mar. 2015).

will be set so as to produce a permanent total cumulative adjustment of -2.85 % by 2022. This proposal produces $9.3 billion in savings over 10 years.[8]

C. PAC Payment Updates

Due to their high Medicare margins, MedPAC recommends freezing the payment updates for IRFs, SNFs, and LTCHs in FY2016. MedPAC also recommends lowering SNF payments by 4 % in 2017 and evaluating whether continued reductions are necessary past 2017.[9]

The President's Budget would reduce market basket updates for IRFs, LTCHs, and HHAs by 1.1 percentage points in each year 2016 through 2025 and reduce market basket updates for SNFs under an accelerated schedule, beginning with a -2.5 % update in FY2016 tapering down to a -0.97 % update in FY 2023. This achieves $102.1 billion in savings over 10 years.[10]

D. Health Home Rebase and Copay

MedPAC reports that two factors have contributed to payments exceeding costs: (1) fewer visits are delivered in an episode than assumed and (2) cost growth has been lower than annual payments updates for the industry. Therefore, MedPAC reiterated its 2011 recommendations for home health payment—that the rate be rebased to reflect actual utilization and costs of providing care, that the home health PPS not use the number of therapy visits provided as a payment factor, and that Medicare establish a copay for episodes not preceded by a hospitalization (since there has been tremendous growth in that patient population).[11]

A home health copay of $100 per home health episode was also included in the President's FY16 Budget for new beneficiaries beginning in 2019. Consistent with the MedPAC recommendations, this copayment would apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. This policy would result in $830 million in savings over 10 years.[12]

It is important to note that the average home health user is more likely than the average beneficiary to be older, sicker, poor, female, and living alone. Beneficiary groups oppose the home health copay. They point out that while limiting the copay to beneficiaries with five or more visits and without a hospital stay is well-meaning, doing so results in a copay that is a more targeted at individuals with long-term chronic conditions who need ongoing home health in order to continue living in the community.

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[8] Office of Management and Budget, The White House, *The President's Budget for Fiscal Year 2016* (online at http://www.whitehouse.gov/omb/budget).

[9] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* (Mar. 2015).

[10] Office of Management and Budget, The White House, *The President's Budget for Fiscal Year 2016* (online at http://www.whitehouse.gov/omb/budget).

[11] Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy* (Mar. 2015).

[12] Office of Management and Budget, The White House, *The President's Budget for Fiscal Year 2016* (online at http://www.whitehouse.gov/omb/budget).

E. IRF Appropriate Use Changes

The President's Budget would adjust the standard for classifying a facility as an IRF starting in 2016. Under current law, at least 60 % of cases admitted to an IRF must meet one or more of 13 designated severity conditions (that standard was once 75 %). This proposal would reinstitute the 75 % standard to ensure that health facilities are classified appropriately based on the patients they serve. This policy would result in $2.2 billion in savings over 10 years.[13]

VI. BACPAC ACT

The BACPAC Act of 2015, establishes a new post-acute care bundled payment system for services otherwise paid for by both Medicare Parts A and B, beginning in 2017. The bundled payment would cover post-acute services within 90 days of hospital discharge, and would exclude physician services, outpatient hospital and therapy services, and hospice care. Payments would be adjusted for geographic variations in cost and patient risk factors as determined by a common patient assessment tool. The legislation requires a 4 % cut to Medicare PAC overall.

The legislation creates a new entity, a PAC Coordinator, under contract with the Secretary, which would receive the Medicare PAC payment for each beneficiary. The PAC Coordinator would distribute the payment to appropriate providers and coordinate care across providers within their established PAC networks. The PAC Coordinator shall keep up to 70 % of any savings achieved after services are paid under the bundled amount and distribute the remainder to the physician, PAC provider, and hospital (if no readmission was present) that serviced the patient. If the patient was readmitted to the hospital within the 90 day period, the Coordinator is fully responsible for those hospital charges.

Patients may select the PAC coordinator of their choosing and must choose among the providers within their PAC Coordinator's network. A PAC coordinator can be hospital, PAC provider, insurer, third-party administrator, or combination of hospital and PAC provider.

The bill also waives several standing Medicare PAC payment requirements: 1) the hospital 3-day stay requirement for skilled nursing facility admission; 2) the requirement for home health services to only be available to home bound patients; 3) the requirement of documentation of a face-to-face encounter for the use of home health services 4) the requirement for inpatient rehabilitation facilities to provide intensive rehabilitation services to a minimum percent (currently 60 %) of patients with specified conditions; and 5) the requirement that a certain percent of LTCH discharges be admitted to the hospital from its co-located hospital.

A. Considerations

- This legislation would establish bundles without first developing a tool to accurately price care provided in the PAC setting (hence Medicare could be paying too much or too little, but we wouldn't know). It is highly unlikely that CMS could develop adequate or appropriate bundles, which would need to be done by reviewing (currently non-existent)

[13] *Id.*

standardized patient assessment data and quality metrics, by 2017. Without this information, it is not possible to ensure patients are placed in the highest quality, lowest cost setting based on their individual diagnoses and characteristics. It seems premature to attempt to bundle episodes before collecting the data required in the IMPACT Act.

- Making bundled payments for PAC care without other necessary PAC reforms, such as addressing PAC providers' roles in unnecessary readmissions, adjusting market basket payments to promote efficiency, and rebasing current over-priced payment systems, patients could be driven to the lowest cost setting (home health) based not on appropriate clinical care, but financial incentives. Home health agencies will be advantaged because the bundle will be higher than their historic payments and inpatient PAC providers (SNF, IRF, LTCH) will be disadvantaged because the bundle will be lower.

- The bill would require the Secretary to ensure that the cost of the bundles do not exceed 96 % of the expenditures that would have been made starting in 2020. The bill also specifies that PAC providers will be paid "an amount that is not less than the amount that would otherwise be paid"—in other words, the bundles have to reduce costs without using provider cuts. Savings can only be generated by reducing prices or volume, and this disallows price reductions, so savings will have to come from volume reduction. Some of the reduction may come from unnecessary services, but without proper quality backstops, it is possible that necessary services will be reduced as well.

- Besides putting the full financial risk of hospital readmission on the Coordinator, the only quality requirements included in the bill are (1) a written plan of quality assurance and improvement from the PAC Coordinator and (2) a written plan of quality assurance and improvement in the PAC network agreement. The Secretary would specify what needs to be in the plan. The bill does not include a requirement to take into account outcomes data in quality metrics. The bill should also indicate that savings will not be shared unless certain minimum quality thresholds are met or it incentivizes skimping on necessary care. It should also include a requirement that all medically necessary services must be delivered.

- The bill does not allow patients to choose a PAC provider out of the chosen Coordinator's network. This is concerning, especially for those patients that have an acute care episode in a location that is not near their home or, for example, would like to choose a PAC provider near family members.

VII. WITNESSES

Panel I

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The Medicare Payment Advisory Commission (MedPAC)

Panel II

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