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“Medicare Post-Acute Care Delivery and Options to Improve It”

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Executive Summary

- I am Len Russ, the Chair of the American Health Care Association (AHCA).
- Skilled nursing centers provide rehabilitative care to more than 2 million Medicare beneficiaries each year. In 2013 the federal government spent \$32 billion on skilled nursing center care, representing 49% of all PAC spending. We differ from other PAC providers in many ways primarily hinging both upon on the long-term relationships we build with the people and families we serve and the complex nature of the skilled nursing center care.
- AHCA recognizes the need to modernize PAC payment systems. The Association supported both the Improving Post-Acute Care Transformation (IMPACT) Act of 2014, the Protecting Access to Medicare Act (PAMA), which included a SNF-specific hospital readmission program.
- Additionally, AHCA has a forward thinking payment reform concept under development, now, which we believe valuable to the unfolding PAC reform dialogue framed by the IMPACT Act.
- The road to PAC reform includes many possibilities including bundling. And, AHCA is interested in bundling as a reform option. To that end, AHCA has six bundling principles which we believe should be met by any bundling proposal. Unfortunately, BACPAC does not meet these principles, therefore, we oppose the measure.
- On a national level, the outcomes of care provided in skilled nursing care centers are steadily improving. The Association and its members have, will continue to make, significant investments aimed at improving quality via our Quality Initiative.

Introduction

Good Morning, Chairman Pitts, Ranking Member Green, and distinguished members of the Committee. I'd like to thank you for holding this hearing to examine options to improve the delivery of post-acute care (PAC), and I especially appreciate the opportunity to appear before you here today. My name is Leonard Russ, and I am the Chairman of the American Health Care Association (AHCA) and the Principal Partner of Bayberry Health Care, New York based partnership specializing in skilled nursing, sub-acute and in-patient rehabilitative care. I am also co-owner of Aaron Manor Nursing & Rehabilitation Center outside Rochester, New York. My facilities have consistently earned four and five star ratings by CMS and have repeatedly been ranked among the Best Nursing Homes in America by US News and World Report. AHCA is the nation's largest association of long term and post-acute care providers with more than 12,000-plus members who provide care to approximately 1.7 million residents and patients every year. Members include not-for-profit and proprietary skilled nursing facilities, assisted living communities, and residences for persons with developmental disabilities. AHCA and the skilled nursing professionals we represent look forward to continuing our work with policymakers to advance long-needed PAC delivery and payment reforms. We are excited to be able to share our views with you today and outline what we believe are rational, achievable steps on that road to true PAC reform.

Background on Skilled Nursing

Skilled nursing centers provide rehabilitative care to more than 2 million Medicare beneficiaries each year. In 2013 the federal government spent approximately \$30 billion on Medicare-financed

skilled nursing center care, representing 49% of all Medicare PAC spending. We differ from other PAC providers in many ways. First, because we are a hybrid of short-term rehabilitation facilities and long-term care facilities, we tend to experience a certain amount of cross-over between the two populations. Stated more plainly, rather than delivering only short-stay rehabilitation services, people also reside in our centers where they receive long term services and supports. Second, we develop relationships with our short-term rehab patients many of whom eventually become our long-term residents. And, as such, we deliver supports and related care management to long-term residents over several years. Third, such experience allows us to deliver care management to both short-stay PAC patients, long-stay residents, as well as when long-stay residents require PAC services following an acute care episode.

In terms of care, when an individual is admitted to a skilled nursing center for rehabilitation, we are held accountable to caring for all of health care needs, even if their full array of care needs are unrelated to the reason for the preceding hospitalization. Data clearly show that patients of skilled nursing centers have more complex and comorbid conditions, such as dementia, compared with the general Medicare population that receives post-acute care services. Because skilled nursing providers are unique in this regard, policy makers should be thoughtful when attempting to make broad comparisons between provider types. We believe PAC reform efforts in today's health care environment are much more likely to succeed if they recognize the nature of SNF patient and resident characteristics and service delivery which differentiate us from other PAC providers.

Regarding payment, AHCA recognizes the need modernize our existing Medicare prospective payment system (PPS). Of note, skilled nursing centers are the only PAC provider type paid

using a per diem system rather than a single payment for an entire PAC stay or episode of care. We agree, and I will discuss later, our preliminary ideas on modernization of our payment system.

For now, I think it important to understand that the goal of many of the payment and delivery system reform efforts is to create incentives for providers to take a more active role in care management and coordination activities. As such models are considered, policy makers should rely upon the knowledge and experience of the skilled nursing profession, such as our care management expertise discussed above, in the design of new payment systems, such as bundled payments and ACOs. We believe leveraging SNF expertise in this area is more effective for patients and residents and more efficient for the Medicare program than introducing third party payers which could consume valuable resources which could be used to improve patient or resident services.

In terms of Congressional action to modernize Medicare-financed PAC services, the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 will finally allow for the collection of equivalent assessment data across PAC provider types and directs MedPAC and the Centers for Medicare and Medicaid Services (CMS) to study and develop an array of quality measures as well a vision for PAC payment reform. CMS IMPACT Act-related efforts likely will rely heavily on the Deficit Reduction Act-mandated PAC Payment Reform Demonstration. AHCA strongly supported the IMPACT Act, as well as the Protecting Access to Medicare Act (PAMA), which included a SNF-specific hospital readmission program. We believe the IMPACT Act contains a thoughtful, staged timeline for PAC reform.

Quality Improvements in America's Skilled Nursing Centers

On a national level, the outcomes of care provided in skilled nursing care centers are steadily improving. In recent years, there have been across-the-board improvements in virtually all quality measures generally used in this field. The proportion of centers receiving the highest rating (i.e., five stars) on the CMS Five-Star Quality Rating System scale increased from 13 percent in 2009 to 28 percent in 2014. Starting in February of this year, CMS arbitrarily rebased scoring for the Five-Star Quality Rating System resulting in an abrupt change in the proportion of centers at each star level, thus, we are not able to compare trends prior to 2015 with current and future time periods.

In early 2012, the Association launched the Quality Initiative, a member-wide challenge to meet specific, measurable targets in four distinct areas: hospital readmissions, staff stability, customer satisfaction and the off-label use of antipsychotic medications. Since the launch of the initiative, members have demonstrated meaningful improvements in quality care for the two goals that we are able to measure using national data sets: hospital readmission and antipsychotic use. AHCA members have reduced hospital readmissions by 14.2 percent (18.3 percent in 2011 to 15.7 percent in 2014). In that same time period, member centers reduced the off-label use of antipsychotic medications by 21.1 percent (23.7 percent in 2011 to 18.7 percent in 2014). National data on turnover and satisfaction is not yet available to adequately evaluate these two goals.

AHCA continues to lead the field and support our members with regard to a focus on systematic improvement and high quality performance. The next phase of our quality initiative, with future

targets and strategies reflective of national priorities outlined in the IMPACT Act and other congressional and administrative efforts to align quality with payment and regulatory policy, will be announced in the coming month.

The AHCA/NCAL National Quality Award Program is a progressive, three-step program based on the nationally recognized Baldrige Performance Excellence criteria. Members can apply for recognition at the Bronze, Silver and Gold levels, each requiring more detailed and comprehensive demonstration of systematic quality performance and organizational effectiveness.

The program is a member of the Alliance for Performance Excellence, an association of the 33 recognized Baldrige-based award programs in the nation. The AHCA/NCAL program is the largest of these programs, with a volume of applications that exceeds the combined total of all the other 32 programs and the National Baldrige program. From 2010–2013, the state and national Baldrige programs received a total of 691 applications; whereas, in the same timeframe, the AHCA/NCAL Quality Award Program received 3,946 applications. As of the 2014 award cycle, 2,988 members have achieved the Bronze Award, 365 members have achieved the Silver Award, and 24 members have achieved the Gold Award. Research demonstrates that AHCA/NCAL Gold and Silver Quality Award recipients consistently outperform other centers on objective quality metrics, readmissions and antipsychotic use.

The (Limited) Skilled Nursing Center Experience with Bundled Payments

AHCA believes implementing true bundled PAC payments will, and should, take several years to test and implement, if done properly. While limited, we do have some experiential evidence from which to draw some preliminary conclusions. The CMS Bundled Payments for Care Improvement (BPCI) initiative, which seeks to test several models of bundled payments across a range of providers, is only now just getting off the ground. Unfortunately, but unsurprisingly, early results are inconclusive, and they raise more questions than answers.

Through regular engagement with AHCA members who are participating in the BPCI initiative at varying stages, we have uncovered a host of operational challenges, as well as policy design flaws, that lead us to believe that truly scalable bundled payments may still be many years out.

For example:

- Current information technology systems and reporting processes do not allow PAC providers to correctly identify patients by the complicated assignment and precedence rules included in the BPCI program. Without being able to identify which patients are bundled payment patients up front, providers are unable to appropriately target those patients with individualized care protocols necessary under a bundled payment model. Anecdotal evidence suggests that skilled nursing providers may be mis-identifying up to 30 percent of patients.
- We have many questions and concerns regarding the role of the non-provider conveners in BPCI. Based on our experience, the role of these conveners is not completely clear to provider participants, or to the industry overall, particularly when the convener is a third-party entity that does not have direct ownership, governance, or management accountability to a provider under the Medicare program. Agreement between third-party

conveners and SNF providers often include shared accountability, a financial relationship and specific programs and services that SNFs receive as part of partnering with a convener. The implications and viability of these relationships are currently not fully clear and largely untested.

- Because the savings requirement under BPCI is directly tracked and attributable at the MS-DRG and clinical condition level by participating SNF, in order for participants to be successful under the program, there must be enough volume within the facility and within the clinical condition to be able to spread actuarial and financial risk and overcome inherent, uncontrollable outliers. While BPCI includes some outlier relief via their risk track options, these risk tracks do not fully mitigate financial risk for participants when outliers occur and on a low volume of cases these outlier impacts are magnified. Most SNFs do not treat a significant volume of patients within each clinical condition during a calendar year, exposing them to these outlier risks and impacts on low volume conditions. This actuarial risk further disadvantages smaller providers, particularly in rural markets.

These represent only a few select examples of the challenges our members are facing under bundled payments. Given what we know so far, and the host of challenges we have been able to identify, we strongly believe a comprehensive bundling approach is premature without more complete results from demonstration efforts, such as BPCI.

The BACPAC Act and AHCA's Approach to Evaluating Bundled Payment Proposals

What we have been able to glean from our members by their participation in BPCI has allowed us to better understand what must, and what must not, be included in any viable bundled

payment legislative proposal. As a result, AHCA has adopted a set of six guiding principles against which to evaluate PAC bundled payment models:

- 1. The policy must place the management of the episode with post-acute care providers.** We believe strongly that providers are the most appropriate and capable entities to manage the care of patients within a post-acute episode, and that inserting a third-party entity between the payer, patients and the provider would create strong incentives to siphon away valuable resources that could otherwise be used in direct patient care.
- 2. The policy must preserve a patient's freedom of choice of provider.** Freedom of choice is a foundational element of the Original Medicare program and should not be limited by attempts to reform payment systems.
- 3. The policy must allow providers the flexibility to deliver patient-centered care in order to achieve the patient's highest practicable level of function and outcome.** We believe the existing regulatory framework should be nimble enough to allow for more patient-centered care in an environment where providers are assuming financial risk, and where incentives are aligned to meet the patient's quality of care and quality of life needs.
- 4. The policy must establish episodes that bundle PAC services only and do not include the immediately preceding acute care hospitalization.** There is strong evidence demonstrating that the acute care delivered to patient does not directly correlate to, nor can it predict, the costs and patterns of the post-acute care that subsequently will be needed. Therefore, trying to develop episodes that encompass both acute and post-acute services is difficult, if not impossible, to do accurately.

5. **The policy must establish “virtual” bundles as opposed to “actual” bundles.** Because the typical marketplace is not organized in a way that allows the typical PAC provider to accept a bundled payment, and to then make payments to other providers, we do not believe prospective bundles could be implemented nationally.
6. **The policy must not inadvertently create access barriers for patients with complex or chronic diseases.** Policies that lack comprehensive, PAC-specific risk-adjustment methodologies, which account for clinical severity and complexity, would create perverse incentives for providers to avoid sicker, more costly patients.

Additionally, we also believe savings should come from more efficient delivery of services and care coordination rather than just from shifting the site of care. When we evaluate the BACPAC Act against our six principles, the measure either directly fails to meet the principle or lacks enough clarity for us to make a determination. Indeed, the lack of clarity in the BACPAC Act is, in our opinion, one of its greatest weaknesses. We believe that there are other paths which policy makers could be explored which would advance PAC reform without creating an unnecessary level of turmoil among providers who must be successful in implementing these reforms and beneficiaries.

AHCA’s Approach to PAC Payment Reform

The Association also wants to be an active participant in PAC payment reform efforts. Last year as Chair of the AHCA Board, I initiated an AHCA/NCAL Payment Reform Initiative. The goal of the effort is to develop a viable, proactive and comprehensive vision for payment reform. As we approached designing our preliminary concept, the membership focused on four criteria: 1) improve quality and patient outcomes; 2) offer savings to the federal government; 3) ensure the

concept may be operationalized by CMS; and 4) offer a viable payment system for all AHCA members.

After considerable member discussion, we crafted a SNF-only episode. Stated another way, we would replace the current per diem payment system and replace it with a single SNF-only episode payment which would cover all SNF Part A services from admission to discharge. Base rates would be based on patient characteristic defined condition categories and would be risk adjusted using an assessment tool. The adjusted rates then would be discounted by some percentage to achieve federal savings. As part of our proposal, we also would partially eliminate the archaic three-day stay. In our proposal, we have included a policy to allow one and two day inpatient hospital short stay patients access to SNF services.

While we still are conducting in depth modeling at the member and SNF market levels, we believe the concept would lay the foundation for out-year IMPACT Act payment reform by moving the SNF profession away from a per diem system to a stay of care or episode of care system there by aligning us with other PAC providers. The concept also would allow SNF providers and CMS to gain experience with a SNF-only stay-based payment as work is conducted on the IMPACT Act vision for a unified, cross-PAC setting payment system based on patient characteristics.

Conclusion

Due to the rehabilitative, rather than curative nature of PAC services, defining services and related payment is particularly difficult. Prior year work, such as the Deficit Reduction Act PAC Payment Reform Demonstration (PAC-PRD) findings, including the CARE Tool, will be

important to IMPACT Act and any other PAC reform efforts. Additionally, development of the PAMA SNF rehospitalization program and related IMPACT Act reporting measures will need to be harmonized with similar efforts underway for hospitals and physicians. AHCA stands ready to work with Congress, members of this and other Committees, as well as other health care providers on a road to PAC payment reform which will improve quality and outcomes for patients and their families.