

**KEEPING THE PROMISE: SITE-OF-SERVICE
MEDICARE PAYMENT REFORMS**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
SECOND SESSION

—
MAY 21, 2014
—

Serial No. 113-148



Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

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U.S. GOVERNMENT PUBLISHING OFFICE

91-549 PDF

WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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KEEPING THE PROMISE: SITE-OF-SERVICE MEDICARE PAYMENT REFORMS

WEDNESDAY, MAY 21, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
Washington, DC.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Lance, Cassidy, Guthrie, Bilirakis, Ellmers, Pallone, Schakowsky, Green, and Barrow.

Also attending: Representative McKinley.

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Mike Bloomquist, General Counsel; Matt Bravo, Professional Staff Member; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Chris Pope, Fellow, Health; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Professional Staff Member, Health; Tom Wilbur, Digital Media Advisor; Ziky Ababiya, Democratic Staff Assistant; Eddie Garcia, Democratic Professional Staff Member; Kaycee Glavich, Democratic Government Accountability Office Detailee; and Amy Hall, Democratic Senior Professional Staff Member.

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's hearing is designed to educate members on a topic that has come up repeatedly in recent years: site-neutral payments. In two recent reports, MedPAC has addressed the differences in Medicare payment rates across sites of care. MedPAC's March 2012 report recommended that payment rates for certain evaluation and management services be equal, whether these services are provided in a hospital outpatient department or in a freestanding physician office.

Currently, hospitals are reimbursed for these services under the Hospital Outpatient Prospective Payment System (HOPPS), and

physicians' offices are reimbursed under the less generous Physician Fee Schedule.

In its June 2013 report, MedPAC discussed equalizing payment rates for certain services in a hospital outpatient setting to those of ambulatory surgery centers (ASCs) and reducing the gap in payment between other services. However, the Commission did not make a recommendation on payment changes. These discussions bring up a number of important issues as it relates to the role that Medicare plays in our health care system. MedPAC has estimated that seniors could save hundreds of millions of dollars a year if a site-neutral payment system were instituted.

In addition, MedPAC cites an urgent need to address these issues because services have been migrating from physicians' offices to the usually higher-paid outpatient department setting as hospital employment of physicians has increased.

While stating the benefits of site-neutral payments and post-acute care (PAC) reform, MedPAC has also expressed some concern that these policy changes could cut access to physician services for low-income patients, noting that a stop-loss policy could protect such patients by limiting hospitals' losses of Medicare revenue. These policies have arisen as potential pay-fors for SGR reform and other health care reforms. As the subcommittee with the largest health jurisdiction of any committee in the House, we are charged with safeguarding the Medicare program and preserving it for future generations.

As such, I and Ranking Member Pallone felt it important for the members of this subcommittee to hear the pros and cons of potential policies in this space. Two pieces of legislation are also before us for consideration today. Representatives Mike Rogers and Doris Matsui introduced H.R. 2869, a proposal that would require Medicare to pay for cancer services at the same rate regardless of the site of service. In addition, Representative McKinley has authored H.R. 4673, a bill that would combine the various post-acute care payments into one reimbursement payment or bundle.

I would like to thank all of our witnesses for being here today to educate Members on both sides of the issue.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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In addition, MedPAC cites an urgent need to address these issues because services have been “migrating from physicians’ offices to the usually higher-paid outpatient department setting, as hospital employment of physicians has increased.”

While stating the benefits of site neutral payments and Post-Acute Care (PAC) reform, MedPAC has also expressed some concern that these policy changes could cut access to physician services for low-income patients, noting that a “stop-loss policy” could protect such patients by limiting hospitals’ losses of Medicare revenue.

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I would like to thank all of our witnesses for being here today to educate Members on both sides of the issue.

[H.R. 2869 and the H.R. 4673 draft follow:]

113th CONGRESS
1st Session
H. R. 2869

To amend title XVIII of the Social Security Act to establish payment parity under the Medicare program for ambulatory cancer care services furnished in the hospital outpatient department and the physician office setting.

IN THE HOUSE OF REPRESENTATIVES

July 31, 2013

Mr. ROGERS of Michigan (for himself and Ms. MATSUI) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to establish payment parity under the Medicare program for ambulatory cancer care services furnished in the hospital outpatient department and the physician office setting.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Medicare Patient Access to Cancer Treatment Act of 2013'.

SEC. 2. FINDINGS; SENSE OF CONGRESS.

(a) Findings- Congress finds the following:

- (1) The National Cancer Institute estimates that approximately 13.7 million Americans with a history of cancer were alive on January 1, 2012.
- (2) About 8 million of the 13.7 million Americans living with cancer are over age 65, and approximately half of cancer care spending is associated with Medicare beneficiaries.

- (3) National spending on cancer care in 2010 is estimated at \$125 billion.
- (4) In 2011, the National Cancer Institute released projections of the cost of cancer care in the United States, finding the total cost of cancer care in 2020 is expected to be \$206 billion.
- (5) In a 2010 study, Milliman reported that in 2007 a cancer patient receiving chemotherapy incurred average costs of approximately \$111,000, three times the cost of a coronary artery disease patient, and six times the cost of a diabetes patient.
- (6) Over the last several years, the United States has been touted as world leader in providing high-quality cancer care.
- (7) United States cancer survival rates are higher than the average in Europe and Canada for 13 of 16 types of cancer.
- (8) Until recently, over 80 percent of United States cancer patients received care in the community setting.
- (9) Over the past several years, the country has experienced a significant shift of outpatient cancer care delivery from the physician's office to the hospital outpatient department.
- (10) Reports show that over the past six years, 43 community practices have started referring all of their patients elsewhere for treatment, 288 oncology office locations have closed, 131 practices have merged or were acquired by a corporate entity other than a hospital, and 469 oncology groups have entered into an employment or professional services agreement with a hospital.
- (11) Over 1,000 clinics or practices have been impacted over the last 3 years out of a population of only 6,000 oncologists in community practice in the United States.
- (12) A 2013 study published by The Moran Company ('Moran study') found that, between 2005 and 2011, there was a 150 percent increase in administered chemotherapy in the hospital outpatient setting for Medicare fee-for-service beneficiaries (increasing from 13.5 percent in 2005 to 33.0 percent in 2011) as compared to administration in physician community cancer clinics.
- (13) The Moran study found that, in 2005, almost 87 percent of Medicare patients were receiving their care in the community setting, by 2011 only 67 percent were utilizing the community setting.
- (14) The Moran study reports that Medicare payments for chemotherapy administered in hospital outpatient settings have more than tripled since 2005 (from \$90 million to \$300 million) while payments to physician community cancer clinics have actually decreased by 14.5 percent.

(15) The Medicare physician fee schedule rate in 2012 for CPT Code 96413 (Chemo, iv infusion, 1 hr), the most common drug administration code billed by oncology practices, is \$139 but the payment rate for the same service under the Medicare hospital outpatient prospective payment system (HOPPS) fee schedule in 2012 is 50 percent higher at \$208.

(16) Utilization-weighted Medicare payment for infusion services is approximately 55 percent higher at the hospital outpatient department than in a physician's office.

(17) Medicare proposed in 2012 to pay hospital outpatient departments 25 percent more for radiation therapy services than for the same services performed in physicians' offices, including a 70 percent differential for intensity modulated radiation treatment (IMRT) and a 188 percent differential for stereotactic body radiation therapy delivery (SBRT).

(18) One third of hospitals in the United States purchase chemotherapy drugs through the section 340B program at a discount of up to 50 percent, resulting in a net cost to such hospitals that typically is at least 30 percent below reimbursement rate (which is based on 106 percent of the average sales price) for community oncologists for such drugs.

(19) Medicare reimburses 70 percent of hospital bad debt (uncollectable coinsurance).

(20) According to an October 2011 Milliman study, the cost of treating cancer patients is significantly lower for both Medicare patients (10 percent lower in copayment amounts, more than \$650 savings a year) and the Medicare program (14.2 percent less, a savings of \$6,500 a year per patient) when provided in community-based cancer settings as compared to the same treatment in hospital outpatient departments.

(21) The April 1, 2013, sequestration cuts to Medicare allowed for a 28 percent cut to the services reimbursement in Medicare part B drugs to community oncologists.

(22) A recent Community Oncology Alliance survey showed that 69 percent of practices surveyed reported that patient treatment or operational changes already have been made due to the sequester cut to cancer drugs, with 49 percent of practices forced to send Medicare patients elsewhere for treatment, and 62 percent of practices reported that they will be forced to send Medicare patients elsewhere for treatment if the sequestration cuts stay in place through July 31, 2013.

(23) The June 2013 report of the Medicare Payment Advisory Commission highlighted the large disparities in payment in outpatient settings and noted that the payment variations across settings should be addressed quickly due to the fact that current disparities have created

incentives for hospitals to buy physician practices, driving up costs for the Medicare program and for beneficiaries.

(b) Sense of Congress- It is the sense of Congress that, to ensure the future of community cancer care, Medicare reimbursement should be equal for the same service provided to a cancer patient regardless of whether the service is delivered in the hospital outpatient department or physician's office.

SEC. 3. EQUALIZING MEDICARE REIMBURSEMENT IN HOSPITAL OUTPATIENT DEPARTMENTS AND PHYSICIANS' OFFICES FOR CANCER CARE SERVICES.

(a) In General- Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended--

(1) in paragraph (2)--

(A) in subparagraph (G), by striking 'and' at the end;

(B) in subparagraph (H), by striking the period at the end and inserting '; and'; and

(C) by inserting after subparagraph (H) the following new subparagraph:

“(l) payment for covered OPD services that are cancer care services (as defined in subparagraph (B) of paragraph (18)) shall be made consistent with subparagraph (A) of such paragraph.”; and

(2) by adding at the end the following new paragraph:

“(18) SPECIAL PAYMENT RULE FOR CANCER CARE SERVICES-

“(A) IN GENERAL- In the case of cancer care services that are furnished on or after January 1, 2014, the payment amount for such services under this subsection and under section 1848 shall be a budget neutral combination (as determined by the Secretary) of--

“(i) the amount otherwise payable under this subsection for such services; and

“(ii) the amount otherwise payable under section 1848 for such services.

“(B) CANCER CARE SERVICES DEFINED- For purposes of this subsection, the term ‘cancer care services’ means covered OPD services or physicians’ services for which payment is made under section 1848 that are furnished in conjunction with the diagnosis or treatment of cancer.’.

(b) Conforming Amendment- Section 1848(a) of Social Security Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

(9) APPLICATION OF SPECIAL RULE FOR CANCER CARE SERVICES- In the case of physicians' services that are cancer care services (as defined in subparagraph (B) of section 1833(t)(18)) that are furnished on or after January 1, 2014, the payment amount for such services under this section shall be the payment amount for such services determined under subparagraph (A) of such section.!

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.....
 (Original Signature of Member)

113TH CONGRESS
 2D SESSION

H. R. _____

To amend title XVIII of the Social Security Act to provide bundled payments for post-acute care services under parts A and B of Medicare, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. MCKINLEY introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to provide bundled payments for post-acute care services under parts A and B of Medicare, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Bundling and Coordi-
 5 nating Post-Acute Care Act of 2014” and as the
 6 “BACPAC Act of 2014”.

7 **SEC. 2. PURPOSES.**

8 The purposes of this Act are to—

1 (1) foster the delivery of high-quality post-acute
2 care services in the most cost-effective manner pos-
3 sible;

4 (2) preserve the ability of patients, with the
5 guidance of their physicians, to select their preferred
6 providers of post-acute care services;

7 (3) promote competition among post-acute care
8 providers on the basis of quality, cost, account-
9 ability, and customer service;

10 (4) achieve long-term sustainability by ensuring
11 operational stability through regional breadth and
12 the engagement of experienced care PAC coordina-
13 tors;

14 (5) advance innovation in fields including tele-
15 health, care coordination, medication management,
16 and hospitalization avoidance; and

17 (6) provide for the financial security of the
18 Medicare program by achieving substantial program
19 savings through maximized efficiencies, cost avoid-
20 ance, and outcomes improvement.

1 **SEC. 3. PROVIDING BUNDLED PAYMENTS FOR POST-ACUTE**
 2 **CARE SERVICES UNDER PARTS A AND B OF**
 3 **MEDICARE.**

4 Title XVIII of the Social Security Act is amended by
 5 inserting after section 1866E (42 U.S.C. 1395cc-5) the
 6 following new section:

7 **“PROVIDING BUNDLED PAYMENTS FOR POST-ACUTE CARE**
 8 **SERVICES**

9 **“SEC. 1866F. (a) IN GENERAL.—**For a PAC bundle
 10 with respect to qualifying discharges occurring on or after
 11 January 1, 2016, instead of the payment otherwise pro-
 12 vided under parts A and B, there shall be paid a single
 13 payment amount (determined under subsection (d) and as
 14 limited under paragraph (4) of such subsection) to be paid
 15 to a PAC coordinator (as described in subsection (e)) se-
 16 lected by an individual under such subsection.

17 **“(b) PAC-RELATED DEFINITIONS.—**In this section:

18 **“(1) PAC BUNDLE.—**The term ‘PAC bundle’
 19 means PAC services furnished to an individual dur-
 20 ing a PAC period in a PAC area.

21 **“(2) PAC SERVICES.—**

22 **“(A) IN GENERAL.—**The term ‘PAC serv-
 23 ices’ includes—

24 **“(i) post-hospital extended care serv-**
 25 **ices, subject to subparagraph (C)(i);**

1 “(ii) home health services, subject to
2 subparagraph (C)(ii);

3 “(iii) inpatient services provided in a
4 rehabilitation facility, subject to subpara-
5 graph (C)(iii);

6 “(iv) inpatient hospital services pro-
7 vided by a long-term care hospital, subject
8 to subparagraph (C)(iv);

9 “(v) durable medical equipment;

10 “(vi) outpatient prescription drugs
11 and biologicals; and

12 “(vii) skilled nursing facility services.

13 “(B) EXCEPTIONS.—Such term does not
14 include—

15 “(i) physicians’ services;

16 “(ii) hospice care;

17 “(iii) outpatient hospital services;

18 “(iv) ambulance services;

19 “(v) outpatient physical therapy serv-
20 ices;

21 “(vi) outpatient occupational therapy
22 services;

23 “(vii) outpatient speech-language pa-
24 thology services; and

1 “(viii) the items and services de-
2 scribed in section 1861(s)(9).

3 “(C) NONAPPLICATION OF CERTAIN COV-
4 ERAGE LIMITATIONS.—

5 “(i) WAIVER OF SKILLED NURSING
6 FACILITY THREE DAY STAY REQUIRE-
7 MENT.—In applying subparagraph (A)(i),
8 the 3-day stay requirement described in
9 section 1861(i) (requiring that an individ-
10 ual’s inpatient stay in a discharging hos-
11 pital be for a duration of not less than 3
12 consecutive days) shall not apply.

13 “(ii) WAIVER OF HOMEBOUND RE-
14 QUIREMENT FOR HOME HEALTH SERV-
15 ICES.—In applying subparagraph (A)(ii),
16 the requirements cited in sections
17 1814(a)(2)(C) and 1835(a)(2)(A) that
18 home health services are or were required
19 because the individual is or was confined to
20 the home of the individual shall not apply.

21 “(iii) NONAPPLICATION OF REHABILITATION FACILITY PERCENTAGE REQUIRE-
22 MENT.—In applying subparagraph (A)(iii),
23 any requirement that a specified percent-
24 age of the inpatient population served by
25

1 the facility require intensive rehabilitation
2 services for treatment of one or more of
3 the conditions specified in section
4 412.29(b)(2) of title 42, Code of Federal
5 Regulations, as of December 19, 2013,
6 shall not apply.

7 “(iv) NONAPPLICATION OF LONG-
8 TERM CARE HOSPITAL PERCENTAGE RE-
9 QUIREMENT.—In applying subparagraph
10 (A)(iv), any requirement that a specified
11 percentage of the discharged Medicare in-
12 patient population of the long-term care
13 hospital or its satellite facility be admitted
14 to the hospital or its satellite facility from
15 its co-located hospital shall not apply.

16 “(3) PAC PERIOD.—The term ‘PAC period’
17 means the period beginning on the date of a quali-
18 fying discharge (as defined in paragraph (10)) and
19 ending on the date that is the earlier of the fol-
20 lowing:

21 “(A) The date that is 90 days after the
22 date of such discharge.

23 “(B) The date on which the individual is
24 admitted to a hospital for purposes of receiving
25 services for a condition that is not related to

1 the condition for which the individual received
2 the acute care inpatient hospital services de-
3 scribed in paragraph (10)(A).

4 “(4) PAC AREA.—The term ‘PAC area’ means
5 an area with respect to which a PAC coordinator
6 has a PAC agreement in effect under subsection
7 (c)(1)(B).

8 “(5) PAC PHYSICIAN.—The term ‘PAC physi-
9 cian’ means, with respect to an individual receiving
10 a PAC bundle, the physician who has primary re-
11 sponsibility with respect to supervising the delivery
12 of services during the course of a PAC period.

13 “(6) PAC PROVIDER.—The term ‘PAC pro-
14 vider’ means, with respect to PAC services, the pro-
15 vider of services or supplier furnishing such services.

16 “(7) PAC NETWORK AGREEMENT.—The term
17 ‘PAC network agreement’ means, in the case that an
18 individual has selected a PAC coordinator under
19 subsection (c)(4)(A) for the furnishing of PAC ser-
20 vices, an agreement of a PAC coordinator with one
21 or more PAC providers to provide such services to
22 such individual.

23 “(8) PAC READMISSION.—The term ‘PAC re-
24 admission’ means, with respect to an individual re-
25 ceiving a PAC bundle, the individual’s admission to

1 a hospital within 90 days of the date of the quali-
2 fying discharge of the individual, for purposes of re-
3 ceiving services for a condition that is related to the
4 condition for which the individual received the acute
5 care inpatient hospital services described in para-
6 graph (10)(A).

7 “(9) PAC ASSESSMENT TOOL.—The term ‘PAC
8 assessment tool’ means the Continuity Assessment
9 Record and Evaluation (CARE) tool (or such equiv-
10 alent assessment tool as the Secretary may specify).

11 “(10) QUALIFYING DISCHARGE.—Subject to
12 subsection (e), the term ‘qualifying discharge’ means
13 a discharge after receiving acute care inpatient hos-
14 pital services (as defined by the Secretary) in a sub-
15 section (d) hospital (as defined in section
16 1886(d)(1)(B)) for which the discharge plan in-
17 cludes the furnishing of PAC services.

18 “(11) CRG.—The term ‘CRG’ means a condi-
19 tion-related group established under subsection
20 (d)(1).

21 “(e) PAC COORDINATORS.—

22 “(1) IN GENERAL.—In this section, the term
23 ‘PAC coordinator’ means an entity (such as a hos-
24 pital, health insurance issuer, third-party benefit
25 manager, or PAC provider) that—

1 “(A) is certified, under a process estab-
2 lished by the Secretary, as meeting appropriate
3 requirements specified by the Secretary, includ-
4 ing the requirements specified in paragraph (2);
5 and

6 “(B) has entered into and has in effect a
7 PAC agreement with the Secretary described in
8 paragraph (3).

9 “(2) REQUIREMENTS.—The requirements speci-
10 fied in this paragraph, with respect to an entity
11 serving a PAC area, are the following:

12 “(A) FINANCIAL SOLVENCY.—The entity
13 has the capacity, and provides sufficient assur-
14 ances of solvency, to bear financial risk as a
15 PAC coordinator under this section.

16 “(B) CAPACITY TO MANAGE CARE AND
17 FUNDING.—The entity has the capability to
18 manage the care and funding for PAC services
19 in such area.

20 “(C) PAC NETWORK AGREEMENTS.—

21 “(i) NETWORK CAPACITY TO SERVE
22 PAC AREA.—The entity has entered into
23 PAC network agreements with one or more
24 PAC providers in a PAC area in a manner
25 sufficient to ensure the availability of PAC

1 services for individuals residing in the area
2 who select the entity for the furnishing of
3 PAC services.

4 “(ii) LIMITATION ON BALANCE BILL-
5 ING.—Such a PAC network agreement
6 shall provide that the PAC provider shall
7 accept as payment in full for PAC services
8 furnished by such PAC provider the appli-
9 cable amount described in paragraph
10 (3)(C).

11 “(iii) QUALITY ASSURANCE.—Such a
12 PAC network agreement shall provide that
13 the PAC provider shall have in effect a
14 written plan of quality assurance and im-
15 provement, and procedures implementing
16 such plan, that meet such quality stand-
17 ards as the Secretary may specify.

18 “(D) CREDIT-WORTHINESS.—The entity
19 has demonstrated credit-worthiness.

20 “(E) MEDICAL DIRECTOR.—The entity em-
21 ploys or contracts with a medical director who
22 has an appropriate medical background.

23 “(3) TERMS OF PAC AGREEMENT.—The PAC
24 agreement described in this paragraph between an
25 entity and the Secretary shall, with respect to the

1 PAC area specified under subparagraph (B), have
2 such terms and conditions as are specified by the
3 Secretary consistent with this section and shall in-
4 clude the following:

5 “(A) CARE COORDINATION.—With respect
6 to an individual who selects the entity under
7 paragraph (4)(A)—

8 “(i) the entity shall select one or more
9 PAC providers in such area to furnish, di-
10 rectly or indirectly, clinically appropriate
11 PAC services (as determined through the
12 use of the PAC assessment tool) to the in-
13 dividual; and

14 “(ii) the entity shall coordinate the
15 furnishing of all such services for the indi-
16 vidual.

17 “(B) PAC AREA COVERED.—The PAC
18 agreement shall specify the PAC area under the
19 PAC agreement.

20 “(C) PAYMENT AMOUNT FOR PAC SERV-
21 ICES.—For PAC services furnished by a PAC
22 provider and furnished with respect to a quali-
23 fying discharge that occurs—

24 “(i) before January 1, 2019, the enti-
25 ty shall pay the PAC provider under the

1 PAC network agreement between the enti-
2 ty and the PAC provider—

3 “(I) with respect to such PAC
4 services that are services for which
5 the PAC provider would receive pay-
6 ment under this title without regard
7 to this section, an amount that is not
8 less than the amount that would oth-
9 erwise be paid to such PAC provider
10 under this title for such services; and

11 “(II) with respect to such PAC
12 services that are services for which
13 the PAC provider would not receive
14 payment under this title without re-
15 gard to this section, an amount speci-
16 fied under such PAC network agree-
17 ment; and

18 “(ii) on or after January 1, 2019, the
19 entity shall pay the PAC provider under
20 such PAC network agreement an amount
21 specified under such agreement.

22 “(D) DISTRIBUTION OF SAVINGS.—Insofar
23 as the payment amount to a PAC coordinator
24 under subsection (d)(3) for a PAC bundle fur-
25 nished to an individual is greater than the ag-

1 aggregate amounts paid to PAC providers under
2 subparagraph (C) for such bundle for such indi-
3 vidual, the entity shall not retain an amount
4 greater than 70 percent of such savings and
5 shall pay an amount equivalent to—

6 “(i) not less than 10 percent of such
7 savings to such PAC providers;

8 “(ii) not less than 10 percent of such
9 savings to the PAC physician of the indi-
10 vidual; and

11 “(iii) in the case that there is no PAC
12 readmission of the individual, not less than
13 10 percent of such savings to the hospital
14 discharging the individual immediately
15 prior to the furnishing of such services.

16 Payments shall be made under each of clauses
17 (i), (ii), and (iii) to individuals and entities
18 independent of whether payment may be made
19 to such an individual or entity under another
20 such clause.

21 “(E) MAINTENANCE OF ADVISORY COM-
22 MITTEE.—The entity shall maintain an advisory
23 committee of PAC providers and of patient
24 stakeholders to advise the entity regarding its
25 activities under this section.

1 “(4) SELECTION AND CHANGE OF SELECTION
2 OF PAC COORDINATORS BY INDIVIDUAL.—

3 “(A) IN GENERAL.—The Secretary shall
4 establish a process for the selection and change
5 of selection of a PAC coordinator by an indi-
6 vidual who is receiving inpatient hospital serv-
7 ices and whose discharge has been or is likely
8 to be classified as a qualifying discharge.

9 “(B) LIMITATION ON SELECTION DUE TO
10 NETWORK ADEQUACY.—The process established
11 under subparagraph (A) may not allow an indi-
12 vidual to select (or to change a selection to) a
13 PAC coordinator in a PAC area unless the PAC
14 coordinator has entered into PAC network
15 agreements with such PAC providers in such
16 PAC area such that the PAC coordinator has a
17 sufficient number and range of health care pro-
18 fessionals and providers willing to provide serv-
19 ices under the terms of the PAC agreement.

20 “(5) CONSTRUCTION RELATING TO PAC COOR-
21 DINATORS OFFERING NON-PAC SERVICES.—Nothing
22 in this section shall be construed as prohibiting PAC
23 providers from offering, either directly or indirectly,
24 services that contribute to patient care, safety, and
25 readmission avoidance (such as medication manage-

1 ment, telehealth technologies, home environment
 2 services, and transportation services) that are not
 3 PAC services.

4 “(6) CONSTRUCTION REGARDING FLEXIBILITY
 5 IN THE DELIVERY OF PAC SERVICES.—Nothing in
 6 this section shall be construed to prevent a PAC net-
 7 work agreement from permitting a PAC provider to
 8 subcontract for the furnishing of PAC services that
 9 the PAC provider is otherwise obligated to provide
 10 under the agreement so long as the subcontractor
 11 meets the same terms and conditions in furnishing
 12 such services as would apply if the PAC provider
 13 were to provide such services.

14 “(d) PAYMENT AMOUNTS.—

15 “(1) CLASSIFICATION OF CONDITIONS BY CRGS;
 16 METHODOLOGY FOR CLASSIFICATION.—The Sec-
 17 retary shall establish a classification of the condi-
 18 tions of individuals receiving a PAC bundle by CRG
 19 and a methodology for classifying specific PAC bun-
 20 dles within these groups. The methodology shall, to
 21 the extent feasible, classify such bundles through the
 22 use of the PAC assessment tool.

23 “(2) COMPUTATION OF BASE RATE.—

24 “(A) IN GENERAL.—The Secretary shall
 25 compute an average payment rate for PAC bun-

1 dles classified in each CRG and furnished dur-
 2 ing a PAC period ending in the base year se-
 3 lected under subparagraph (B).

4 “(B) BASE YEAR SELECTION.—The Sec-
 5 retary shall select as a base year the most re-
 6 cent year ending before the date of the enact-
 7 ment of this section for which data are available
 8 to carry out this section.

9 “(C) BUDGET-NEUTRAL COMPUTATION.—
 10 The average payment rate for a PAC bundle
 11 classified in a CRG shall be computed in a
 12 manner so that, if it had been applied in the
 13 base year, the aggregate payments for PAC
 14 bundles classified in such CRG and furnished
 15 during a PAC period ending in such year would
 16 be equivalent to the aggregate payments under
 17 this title for such bundles.

18 “(3) CALCULATION OF PAYMENT AMOUNT
 19 BASED ON BASE RATE.—Subject to the succeeding
 20 provisions of this subsection, the amount of the sin-
 21 gle payment described in this paragraph, with re-
 22 spect to a PAC bundle classified within a CRG and
 23 furnished to an individual during a PAC period end-
 24 ing—

1 “(A) in 2016, is the base average payment
2 rate for such bundle computed under paragraph
3 (2), increased by such percentage as the Sec-
4 retary estimates is the average rate of increase
5 in payments under this title for such bundle be-
6 tween the base year and 2016; and

7 “(B) in a subsequent year, is the amount
8 of the single payment for such bundle computed
9 under this paragraph for the previous year, in-
10 creased by a percentage specified by the Sec-
11 retary consistent with paragraph (4).

12 “(4) CALCULATION OF ANNUAL PERCENTAGE
13 INCREASE.—In calculating the percentage increases
14 applied under paragraph (3)(B), the Secretary shall
15 ensure that total expenditures for all PAC bundles
16 provided in accordance with this section do not ex-
17 ceed 96 percent of the applicable baseline over the
18 8-fiscal year period beginning with fiscal year 2016.

19 “(5) ADJUSTMENT FOR READMISSIONS DURING
20 PAC PERIOD.—The amount paid to a PAC coordi-
21 nator under this subsection for a PAC bundle in a
22 PAC period that includes a PAC readmission shall
23 be reduced by an amount equal to the aggregate
24 amount of payments made for such PAC readmis-
25 sion of such individual.

1 “(6) ADJUSTMENT FOR GEOGRAPHIC AND RISK
2 FACTORS.—The Secretary shall adjust the amount
3 of payment described in paragraph (3) with respect
4 to services furnished to an individual in a PAC area
5 in a budget-neutral manner for a year—

6 “(A) by an appropriate factor that reflects
7 variations in costs for the furnishing of PAC
8 bundles among different geographic areas;

9 “(B) by an appropriate factor that ac-
10 counts for variations in costs for the furnishing
11 of such PAC services to the individual based
12 upon the health status of the individual; and

13 “(C) by an amount that accounts for his-
14 torical local (hospital referral cluster) pricing.

15 “(7) ADJUSTMENT IN CASE OF CHANGE OF SE-
16 LECTION BY INDIVIDUAL.—In the case of a change
17 of selection of PAC coordinator by the individual
18 under subsection (e)(4) during a PAC period, the
19 Secretary shall adjust the amount of payment de-
20 scribed in paragraph (3) in order to provide appro-
21 priate partial payments to be paid to the PAC coor-
22 dinator selected initially by the individual and to the
23 PAC coordinator selected under the change of selec-
24 tion by the individual. The method of calculating the
25 respective amounts of such appropriate partial pay-

1 ments shall be based on the method used for the
2 Home Health Partial Episode Payment adjustment.

3 “(8) USE OF PAC ASSESSMENT TOOL FOR PUR-
4 POSES OF ADJUSTMENT FOR RISK FACTORS.—In de-
5 termining an appropriate factor under paragraph
6 (6)(B) with respect to an individual, the Secretary
7 shall take into account an assessment of the indi-
8 vidual conducted using the PAC assessment tool.

9 “(e) PHASE-IN.—

10 “(1) DETERMINATION OF PAC EXPENDITURES
11 BY CRG.—Based on the most recent data available,
12 the Secretary shall determine the aggregate amount
13 of expenditures under this title for PAC services fur-
14 nished during the PAC period for each CRG (as de-
15 fined in paragraph (b)(11)).

16 “(2) RANKING OF CRGS BY VOLUME OF EX-
17 PENDITURE.—The Secretary shall rank the CRGs in
18 order based on the aggregate amount of expendi-
19 tures for PAC services described in clause (i) for
20 each CRG.

21 “(3) GROUPING OF CRGS.—The Secretary shall
22 group CRGs into four groups as follows:

23 “(A) FIRST GROUP.—The first group con-
24 sists of the CRGs that have the highest rank
25 under clause (ii) and that collectively account

1 for 25 percent of the aggregate amount of ex-
 2 penditures for PAC services described in clause
 3 (i).

4 “(B) SECOND GROUP.—The second group
 5 consists of the CRGs that have the next highest
 6 rank under clause (ii) after the first group in
 7 subclause (I) and that collectively account for
 8 25 percent of the aggregate amount of expendi-
 9 tures for PAC services described in clause (i).

10 “(C) THIRD GROUP.—The third group con-
 11 sists of the CRGs that have the next highest
 12 rank under clause (ii) after the second group in
 13 subclause (II) and that collectively account for
 14 25 percent of the aggregate amount of expendi-
 15 tures for PAC services described in clause (i).

16 “(D) FOURTH GROUP.—The fourth group
 17 consists of the CRGs that are not included in
 18 the first, second, or third group under this
 19 clause.

20 “(4) PHASE-IN BY CRG GROUPING.—In apply-
 21 ing this section for discharges in—

22 “(A) 2016, only discharges that are classi-
 23 fied within the first group under subclause (I)
 24 of clause (iii) shall be included;

1 “(B) 2017, only discharges that are classi-
2 fied within the first or second group under sub-
3 clause (I) or (II) of clause (iii) shall be in-
4 cluded;

5 “(C) 2018, only discharges that are classi-
6 fied within the first, second, or third group
7 under subclause (I), (II), or (III) of clause (iii)
8 shall be included; and

9 “(D) 2019 and subsequent years, dis-
10 charges that are classified within any group of
11 CRGs shall be included.”.

12 **SEC. 4. TRANSITIONAL CARE MANAGEMENT PAYMENTS**
13 **FOR PHYSICIANS.**

14 For purposes of encouraging transitional care man-
15 agement by PAC physicians (as defined in section
16 1866F(b)(5) of the Social Security Act), in carrying out
17 section 1848(e) of the Social Security Act (42 U.S.C.
18 1395w-4(e)), the Secretary of Health and Human Serv-
19 ices shall establish a new Transitional Care Management
20 (TCM) code to pay for care management by such a PAC
21 physician or revise and expand the use of existing TCM
22 codes 99495 and 99494.

Mr. PITTS. I will yield the remainder of my time to the gentleman from Michigan, Mr. Rogers.

OPENING STATEMENT OF HON. MIKE ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. ROGERS. Thank you, Mr. Chairman, for holding this important hearing on H.R. 2869, the Medicare Cancer Patient Protection Act.

The United States is home to the most effective and successful cancer care in the world, creating an environment that has resulted in the best cancer survival rates across the globe. However, in the last 5 years, a troubling change in the delivery of cancer care has begun to emerge, a change that has been directly affecting not just the continuing rise in the cost of Medicare but also the ability for cancer patients to access treatment.

Since 2008, community oncology clinics have seen the shift from physician office setting to the hospital outpatient department as a result of the flawed Medicare payment policies that reimburse hospitals at higher rates than oncology clinics for the exact same service.

Due to the significant changes in Medicare payment policies, physician practices are suffering from serious financial difficulties and struggling to keep their doors open. These changes have serious implications on patient access, especially in rural areas, where radiation therapy is not always available through local hospitals. Patients may be forced to travel long distances to receive care, posing a considerable barrier to care for beneficiaries who require radiation treatment therapy daily for months at a time, and by the way, we have examples of those very scenarios.

Moreover, this shift in setting for cancer treatment poses a threat to the solvency of Medicare as hospital consolidation of physician practices is driving up costs for the Medicare program, and more importantly, driving up cost for cancer patients themselves. Reimbursement should be equal for the same service provided to a cancer patient regardless of whether the service is delivered in the hospital outpatient department or a physician's office.

I look forward to working with my colleagues to ensure the future of community cancer care is preserved, and Mr. Chairman, I thank you, and I thank you again for taking up and having this discussion on this very important issue, and I would yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognize the ranking member of the subcommittee, Mr. Pallone, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and I am glad to see the committee taking interest in issues of post-acute care reform.

For many years, there has been a lot of discussion about how we move our health care system into one of quality and efficiency. In fact, if we are going to ensure that Medicare is strong for our Na-

tion's seniors well into the future, we must diligently evaluate how we pay doctors and how we incentivize care.

MedPAC has been reminding Congress of these issues and the need for action in this area for some time. Their work and recommendations should be a useful guide for our efforts, and I thank Mr. Miller for being here today to review MedPAC's perspectives on such reforms.

I also welcome the witnesses on the second panel, who have important perspectives to offer to these topics, and thank you all for being here today.

As you know, the Affordable Care Act recognized the need for reform in the post-acute care (PAC) setting and put in motion a number of initiatives that will build towards PAC reform. Medicare is testing a number of payment system reforms such as bundled payments, value-based purchasing and accountable care organizations that will inform and help to improve care and outcomes in this area.

We know there is a lot of variation in the quality outcomes and costs of PAC around the country. Medicare pays indiscriminately for care in the PAC setting. We don't know if one side of care is better than another for a patient with a particular condition. We don't know what combination of services produces better outcomes or even what level of services is optimal for a given condition.

Medicare spends \$62 billion on post-acute care in the fee-for-service setting in 2012. That is a big price tag, so it is critical we get a handle on these issues quickly. We can't improve the accuracy and efficiency of care if we don't know what we are buying, and efforts to decrease waste in the system will fall short of our dual goals of care delivery and payment reforms.

Before we can envision a wholesale redesign of the payment system, however, we need more data. We do not have any common and comparable data across providers like skilled nursing facilities, home health agencies and others to determine which patients fare best in which settings or even what appropriate levels of care are for patients of varying acuity.

So Mr. Chairman, I commend the House Ways and Means and the Senate Finance Committees for putting out bipartisan draft legislation on that issue to get the discussion started, and I hope to engage with these colleagues as policy proposals are further considered and refined, and in fact, I think you would agree, the House Energy and Commerce Committee should play a part in that conversation as we move forward.

We also know there are efficiencies and improvements to payment accuracy that must be done and can be done now such as ensuring the current payment system is providing the right incentives for quality care rather than encouraging care delivery that maximizes profits. Our committee clearly has a role to play in advancing positive beneficiary-focused reforms related to post-acute care for Medicare beneficiaries, and I hope that we can continue the bipartisan tone in this area and work to develop solutions in the near future.

Thank you again, Mr. Chairman, and thanks, everyone, for joining us today, and I look forward to continuing to strengthen Medicare for the future.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the committee, Dr. Burgess, 5 minutes for opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman. Thank you for the recognition, and special acknowledgement to a physician from Texas, Dr. Barry Brooks, who has joined us in the committee before. It is at this point in the hearing where I usually offer the observation that one day it is my hope that we will have arrayed on the witness table five physicians, who will tell us how much economists ought to be paid, but until that day, we will go with what we have got. We do have doctors on the second panel, and for that, I am extremely grateful.

So we are coming up on the 50th anniversary of the enactment of Medicare, in fact, 49 years ago this summer. The practice of medicine has changed a lot since 1965. I used to tease my dad back then that they had only had two drugs back then, penicillin and cortisone, and they were interchangeable. He didn't think that was very funny either.

But the practice of medicine has changed, and so has the Medicare benefit, and that is a good thing. Now we are asking themselves if the payment structures must also be modernized so that the dollars are spent the way they are intended, that is, efficiently and effectively. Payments to doctors' offices and hospitals are sometimes misaligned with the true cost of care. Sometimes the same services are provided to patients at significantly different rates, depending upon location, with no real difference in the quality or the outcome. Payments for patient care in inappropriate or less optimal settings, of course, can lead to higher long-term costs.

I think that one of the things on this committee we must be careful about is that we do not create a race to the bottom. It is not a question of deciding what is the LD-50 of what doctors can survive on. The lethal dose 50 is 50 percent of what doctors could live on. We are not trying to ascertain the figure. The lowest payment is not always the most appropriate payment, and we should not shy away from paying for better outcomes.

I would agree with the ranking member of the subcommittee that it is important that this committee had an important role to play and the jurisdiction of this committee is the appropriate place for having these discussions. I know I have done significant work on the cost drivers of dual eligibles. It is important for us to guard this population by ensuring we are exercising the jurisdiction of this committee to improve care in all settings.

I thank the chairman for the recognition, and I will yield time to the gentleman from West Virginia, Mr. McKinley.

OPENING STATEMENT OF HON. DAVID B. MCKINLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. MCKINLEY. Thank you, Mr. Chairman and Dr. Burgess, for holding this hearing on H.R. 4673.

Alarmists scare seniors by suggesting that cuts to Medicare are coming. We hear it all the time, all during the campaigns, all through sessions. I am here to say they don't have to be.

For the past 2 years, our staff has been working with various stakeholders to create a program that would make Medicare more efficient and improve health care for seniors without making cuts to provider payments.

The bill before us would do just that. This bill develops a model for post-acute care services, which will increase efficiency, encourage more choice and personalize care for patients, and offer significant savings to the program in the process. Estimates by independent experts have determined that this bill could save as much as 85 to 100 billion dollars. We are not cutting funding for Medicare. We are encouraging efficiency in services and programs that are more patient-centered.

Similar models have already been developed for primary care that has saved 24 percent using efficiency models. By improving our efficiency, we will strengthen the Medicare program without cuts.

Some here today have already suggested that we need to study this issue further. We have had plenty of studies. In my 4 years in Congress this issue has been hanging for 4 years, and we keep talking about studying it. It is time we do something about it. It is time to paint or get off the ladder.

Again, thank you, Mr. Chairman, for this opportunity, and I yield back my time.

Mr. PITTS. The Chair thanks the gentleman, and that concludes the opening statements. All members' opening statements will be made part of the record.

We have two panels. Before we do that, I would ask for unanimous consent to include the following statements for today's hearing record from the AMAC, that's the Association of Mature American Citizens; from the AAFP, the American Academy of Family Physicians; the AOPA, the American Orthotics and Prosthetics Association; from NAHC, the National Association for Home Care and Hospice; and a collective cardiology letter on behalf of the ASES, the American Society of Echocardiography; the ASNC, the American Society of Nuclear Cardiology; and the CAA, the Cardiology Advocacy Alliance; and the Premier Health Care Alliance. Without objection, so ordered.

[The information follows:]



May 19th, 2014

The Honorable Joe Pitts
16th District, Pennsylvania
420 Cannon House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
6th District, New Jersey
237 Cannon House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone,

On behalf of the 1.2 million members of the Association of Mature American Citizens (AMAC), I am submitting this letter to be entered into the Congressional Record regarding the Subcommittee's hearing entitled, "Keeping the Promise: Site of Service Medicare Payment Reforms."

AMAC – the Association of Mature American Citizens – believes that payment reform is a sensible first step in ensuring the long-term stability of the Medicare program. Reform should recognize and embrace market forces as a means of deflating costs and any legislation proposed should emphasize market-driven, consumer-centric solutions that place control of an individual's health care into the hands of the beneficiary. Medicare operates most efficiently and effectively when competition and choice are acting to drive down costs and meet consumers' needs and these pillars of capitalism are critical to keeping Congress' promise to mature Americans and seniors.

As the fastest-growing alternative senior advocacy organization, AMAC remains concerned about the future of the Medicare program, particularly in the wake of numerous cuts to Medicare used to fund the Affordable Care Act. AMAC wholly supports the Subcommittee's ongoing efforts to evaluate how Medicare can be improved in order to guarantee the program's continuation for future generations of Americans. We thank you for your concern and attention to this critical matter and we look forward to the Committee's exploration of solutions to strengthen and streamline the Medicare program.

Sincerely,
Dan Weber
President and Founder of AMAC



Statement of the American Academy of Family Physicians

House Committee on Energy and Commerce Subcommittee on Health Hearing on “Keeping the Promise: Site-of-Service Medicare Payment Reforms” 2123 Rayburn House Office Building

May 21, 2014

The American Academy of Family Physicians (AAFP), representing 115,900 family physicians and medical students nationwide, thanks the Subcommittee for holding this hearing and submits the following statement for the record:

Site Neutrality

The AAFP supports Medicare payment neutrality across sites of service. That is, the AAFP believes that Medicare should not pay significantly more for a service in the hospital outpatient or ambulatory surgery center (ASC) setting than in the physician office setting, as long as the service can be provided safely in the physician office.

The AAFP notes several recent proposals in this vein that are before the Committee today:

- The Medicare Payment Advisory Commission’s (MedPAC) March 2012 recommendation that Congress direct the Centers for Medicare and Medicaid Services (CMS) to reduce payment for evaluation and management (E&M) services provided in a hospital outpatient department so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office.
- The *Medicare Patient Access to Cancer Treatment Act of 2013* (HR 2869), introduced by Reps. Mike Rogers (R-MI) and Doris Matsui (D-CA), which would direct CMS to equalize payment between hospital outpatient departments and physician offices for cancer-care services.
- MedPAC’s March 2014 recommendation that Congress direct CMS to reduce or eliminate differences in payment rates between outpatient departments and physician offices for 66 selected ambulatory payment classifications (including E&M services).

The AAFP supports these and other policies that seek to incentivize the delivery of care in the least costly setting—provided that the service can be delivered safely in that setting. Accordingly, the

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AAFP encourages the Committee and Congress to develop incentives for services to be performed in the lower-cost setting. According to MedPAC's analysis, Medicare beneficiaries would also benefit from site-neutrality, through a net reduction in cost sharing of \$100 million per year. See MedPAC Report to the Congress at p. 84 (Mar. 2014).

Transition Care Management Codes

Referring to Section 4 of the *Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014*, sponsored by Rep. David McKinley (R-WV), and also before the Committee today, the AAFP notes that the Act would require CMS to "establish a new Transitional Care Management (TCM) code to pay for care management by such a [post-acute care] physician or revise and expand the use of existing TCM codes."

The existing TCM codes (CPT 99495 and 99496) first became reimbursable on January 1, 2013. These codes are designed to compensate a patient's physician or practitioner for the expenses associated with coordinating the patient's care in the 30 days following a hospital or nursing facility stay. Although they were billed minimally in 2013 (after only about 2.3 percent of hospital discharges),¹ the AAFP continues to believe that these codes are promising in terms of their ability to align resources to facilitate the immediate interventions by primary care physicians, with their patients, to avoid preventable hospital readmissions. Several factors may be contributing to the slow uptake of the TCM codes. Anecdotal evidence among AAFP membership indicates that some family medicine practices' management and billing systems are not yet equipped to handle the codes (since the practice must hold the claim until the 30-day period is over); some members may be unwilling to be early adopters of a new code for lack of familiarity; others may simply lack awareness of the codes.

The AAFP continues to promote the use of the TCM codes among its membership, and welcomes the leadership of the Committee in making these codes easier to use for primary-care physicians.

Post-Acute Care

Section 3 of the *Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014* adds Section 1866F to the Social Security Act, which among other things eliminates application of the 3-day inpatient hospital stay requirement. The AAFP supports this step as a move away from the arbitrary and outmoded prerequisite that Medicare will not pay for a patient assignment to skilled-nursing care unless the patient has a medical condition that entails at least 3 days of hospital treatment first.

Physicians who, based on their training and experience, use their medical judgment to order a patient into skilled nursing care directly from the community should be encouraged to do so based entirely on patient need, and without worrying whether Medicare will or will not cover the cost of the patient's care.

¹ According to Medicare claims data, code 99495 was reported 143,620 times. Code 99496 was reported 118,961 times. Medicare data also reports 11,180,000 Medicare acute-care hospital discharges in 2012. Assuming that there were at least as many discharges in 2013, physicians billed the TCM codes in conjunction with about 2.3 percent of all hospital discharges.

The AAFP views pending proposals in Congress to count observation days toward the 3-day stay as a positive step forward for patients,² but only a repeal of the 3-day rule will give physicians the ability to admit patients to the most medically appropriate setting without regard to whether Medicare will cover the benefit.

Thank you for the opportunity to provide family medicine's views on the evolving efforts to reform health-care delivery and payment.

² E.g. *The Improving Access to Medicare Coverage Act of 2013* (HR 1179 / S 569).



American Orthotic &
Prosthetic Association

**Statement of the American Orthotic and Prosthetic Association on
Medicare Site of Service & Related Issues of Cost Effectiveness of Orthotic & Prosthetic
Care and on RAC Audits, May 21, 2014**

The American Orthotic and Prosthetic Association (AOPA) is pleased to provide this statement concerning Medicare fraud and the delivery of care to Medicare beneficiaries who have suffered a loss of a limb or impaired use of a limb or the spine. AOPA, founded in 1917, is the largest orthotic and prosthetic (O&P) trade association, with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment. Members include patient care facilities, manufacturers and distributors of prostheses, orthoses, and related products, and educational and research institutions. The field of providing artificial limbs or customized bracing for those Medicare beneficiaries with limb loss or limb impairment is a highly specialized area representing a small, roughly one-third of 1 percent, slice of Medicare spending but has a huge impact on restoring mobility to those patients served. A replacement limb may mean the difference between returning to work and a former life quality and remaining an active and contributing member of society. Customized orthotic bracing solutions for chronic conditions may have a similar long range impact.

The Cost-Effectiveness of O&P

This statement addresses the cost-effectiveness of O&P and refers to a major new study commissioned by the Amputee Coalition and conducted by Dr. Allen Dobson, health economist and former director of the Office of Research at CMS (then the Health Care Financing Administration)¹. This study shows that the Medicare program pays more over the long-term in most cases when Medicare patients are not provided with replacement lower limbs, spinal orthotics, and hip/knee/ankle orthotics.

Lower extremity and spinal orthotic and prosthetic devices and related clinical services are designed to provide stability and mobility to patients with lower limb loss or impairment and spinal injury. Supplying bracing or support (an orthosis) where needed or a new artificial limb (prosthesis) when necessary saves our healthcare system significant future costs. Medicare's own data shows this to be the case. Timely treatment that preserves or helps regain mobility not only makes sense; it also saves dollars.

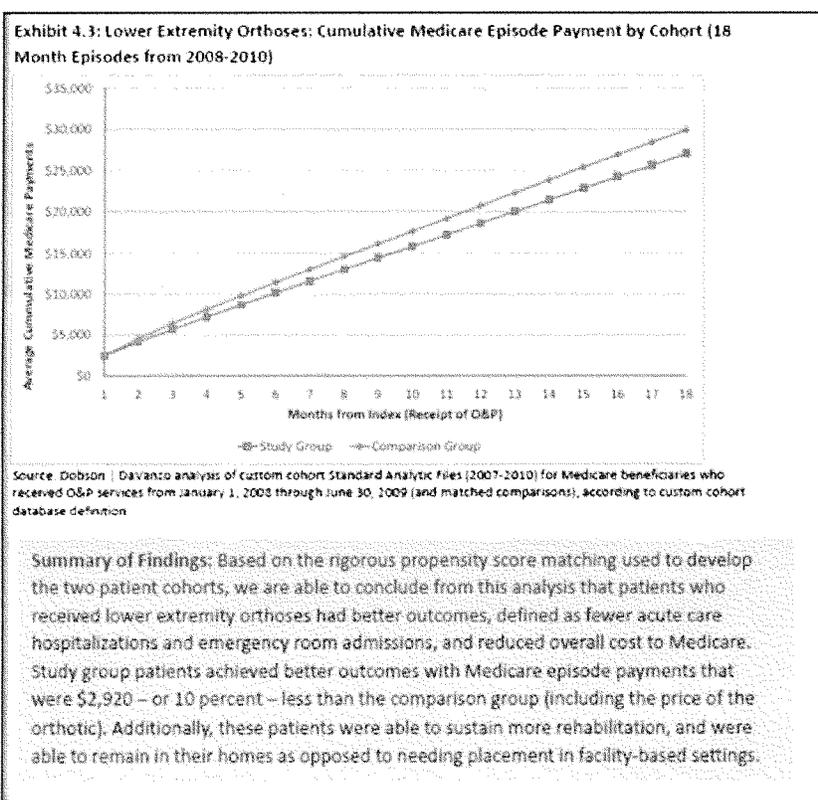
The study's authors used the Medicare Claims database to review all Medicare claims data for patients with conditions that justified the provision of lower limb orthoses, spinal orthoses, and lower limb prostheses. The unprecedented study looked at nearly 42,000 paired sets of Medicare

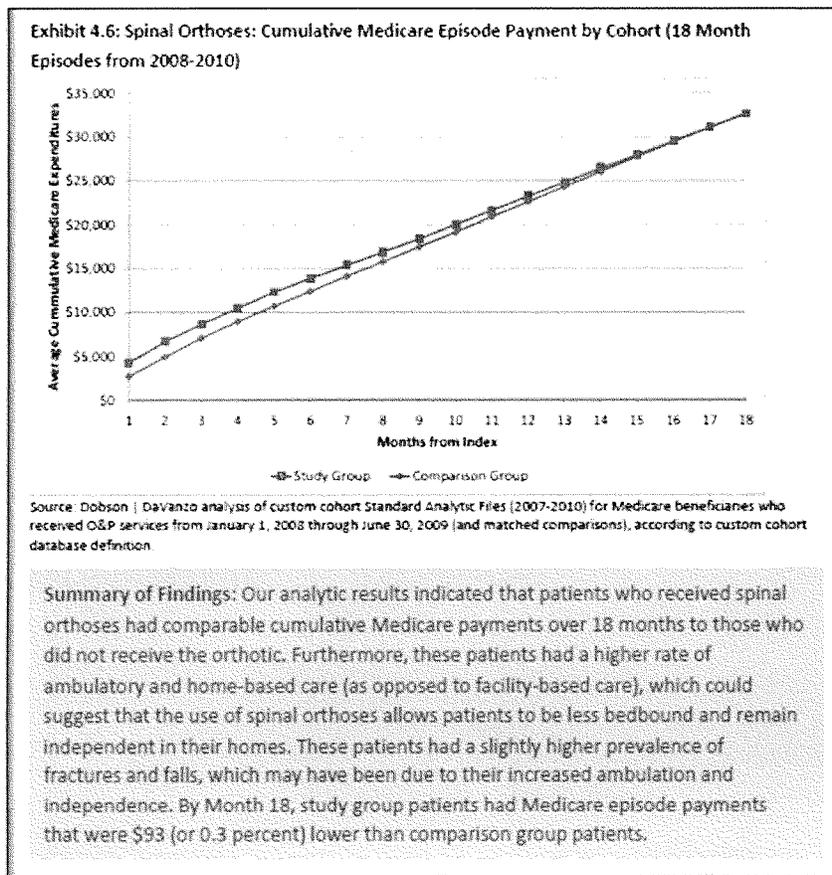
¹ A detailed summary of the research is available online at <http://www.amputee-coalition.org/content/documents/dobson-davanzo-report.pdf>.

beneficiaries with claims from 2007-2010. The paired patients either received full orthotic and prosthetic care or they did not get such care.

The study's key finding was that Medicare costs are lower or similar for patients who received orthotic or prosthetic services, compared to patients who need, but do not receive, these services. According to the study, Medicare could save 10 percent (\$2,920 on average) for those receiving lower extremity orthoses, and there also are modest savings for patients receiving spinal orthoses and lower extremity prostheses.

Without question, the orthotic solutions, as demonstrated by the following two exhibits, reduced healthcare costs in the eighteen months that followed treatment as compared with healthcare costs incurred by the untreated comparison group.





Prosthetics are typically higher cost items, yet the data analysis that compares the two groups showed that in the ensuing twelve months, those not receiving prosthesis incurred almost as much total healthcare expense as those who did receive prosthesis. The following two exhibits suggest that the Medicare program may save on the costs associated with providing prosthesis if a slightly longer term is measured.

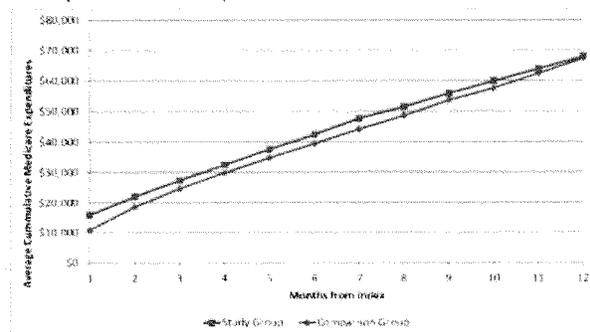
Exhibit 4.8: Lower Extremity Prostheses: Average Use of Inpatient and Outpatient Therapy and Patient Outcomes by Cohort (18 Month Episodes from 2008-2010)

Therapy Use and Outcomes	Study Group	Comparison Group	Difference
Average Number of IRF Days	1.61	1.19	0.42
Average Number of OP Therapy Visits	56.1	28.9	27.18*
Average Number of Fractures and Falls	0.90	0.72	0.18
Average Number of ER Admissions	1.55	2.10	-0.55*
Total Average Medicare Episode Payments	\$68,040	\$67,312	\$728

Source: Dobson | DaVanzo analysis of custom cohort Standard Analytic Files (2007-2010) for Medicare beneficiaries who received O&P services from January 1, 2008 through June 30, 2009 (and matched comparisons), according to custom cohort database definition.

Exhibit 4.9 presents the cumulative episode payment for the study and comparison group by episode month. This chart indicates that the cost of the prosthetic in Month 1 was slowly amortized over time; by the end of Month 12, the cumulative Medicare episode payment for the study group was \$728 (1 percent) higher than the comparison group patient, indicating that the cost of the prosthetic was nearly fully amortized. Due to the correlation between the monthly payments each month after the receipt of the prosthetic, we were unable to draw conclusions beyond Month 12.

Exhibit 4.9: Lower Extremity Prostheses: Cumulative Medicare Episode Payment by Cohort (18 Month Episodes from 2008-2010)



Source: Dobson | DaVanzo analysis of custom cohort Standard Analytic Files (2007-2010) for Medicare beneficiaries who received O&P services from January 1, 2008 through June 30, 2009 (and matched comparisons), according to custom cohort database definition.

Of course the data cannot reflect the improved quality of life enjoyed by beneficiaries in both groups.

This is a clear win for patients and a win for taxpayers, the Medicare system, and private payers. Not only do patients who get full O&P treatment benefit the most, but it also ends up costing taxpayers and insurers less in most cases. Medicare and other payers' preconception that prosthetic limbs and bracing cost money have been disproven by Medicare data. For the first time, actual data demonstrate that O&P devices save health care dollars, confirming the value of O&P intervention based on economic criteria. The goal of restoring function is emphasized in many of Medicare's covered services and therefore supports the targeted use of O&P services for

patients who are able to benefit from and receive the requisite therapy. Increased physical therapy among O&P users allows patients to become less bedbound and more independent, which may be associated with higher rates of falls and fractures but fewer emergency room admissions and acute care hospital admissions. This reduction in health care utilization ultimately makes O&P services cost-effective for the Medicare program and other payers, while improving the quality of life and independence of the patient.

The Rationale for Excluding O&P from Post-acute Care Bundles

For several reasons, O&P and related services should be excluded from any post-acute care bundles. First, prosthetics and orthotics (artificial limbs and orthopedic braces) differ markedly from durable medical equipment (DME). Furnishing O&P is not the distribution of commodities like DME; rather O&P care involves an ongoing series of clinical services provided by licensed and/or certified professionals that results in the ability to regain or maintain ambulation and full function. Under the present Medicare structure, beneficiaries with limb-loss or limb-impairment are permitted to choose the licensed and/or certified health care professional with whom they establish a patient care relationship. The patient has the right to choose a provider with whom he or she is comfortable and who best addresses his or her mobility needs. This relationship should be determined on more than the lowest price.

Experience with hospital DRGs and with SNFs shows that some providers have responded to comparable bundling systems by delaying and denying O&P patient care until a patient was discharged, allowing Medicare Part B to cover the cost of O&P treatment, rather than the Part A bundle. Patient quality of care declined with these inappropriate delays in access to O&P care, often irreversibly compromising independent living and relegating the patient to nursing home care. It is imperative to avoid this same kind of result for mobility-compromised patients, militating in favor of exempting O&P from the post-acute care bundle.

In addition, Congress and CMS have determined that competitive bidding is an ill-suited means of providing complex O&P care to Medicare patients. Bundled payments are poorly suited for the delivery of custom O&P care because the devices and related clinical services are unique and cannot be accommodated by a system that relies on a comparison between what may seem to be similar or substitute items and services. To include O&P in bundling would be a radical change to the Medicare system and catastrophic for these limb-impaired individuals.

Congress dealt with this appropriately in 2003 when it exempted all prosthetics and custom orthotics from Medicare competitive bidding. Congress limited competitive bidding to only "off-the-shelf" orthotics, which Congress defined as devices that could be used by the patient with "minimal self-adjustment" and that do not require any expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. The number of "off-the-shelf" orthotic devices is limited, both in number and in potential savings from bidding and bundling.

We believe Medicare beneficiaries would be served best by exempting O&P care from bundled payments and preserving the licensed and/or certified prosthetist/orthotist relationship in the same way the patient's right to select a physician or a physical/occupational/speech therapist is protected. That would be the safest route to protect these limb-impaired Medicare beneficiaries.

We appreciate that Rep. McKinley's legislative proposal, the Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014 contains such an exemption, and we urge that this exemption be maintained.

Other Key Issues Relating to Fraud, Abuse, RACs and ALJ Delays

Section 427 of the Beneficiary Improvement and Protection Act (BIPA) of 2000 requires CMS to ensure that Medicare payments for custom fabricated orthotics and all prosthetics are furnished by "qualified practitioners" and "qualified suppliers." The O&P profession supported this effort and consistently has pushed to have this requirement implemented. Currently, 14 states have enacted O&P licensure statutes. In 2005, CMS issued Transmittal 656 to Medicare payment contractors specifying that contractors must have claims processing edits in place to make sure that in those states where O&P must be provided by a licensed or certified orthotist or prosthetist, payments are made only to practitioners and suppliers that meet relevant state O&P licensure laws. However, CMS has not taken concrete steps to enforce this requirement.

H. R. 3112, the Medicare Orthotics and Prosthetics Improvement Act of 2013, has been introduced in Congress and would build upon the fraud-fighting provisions included in BIPA. It would help reduce fraud, protect patients, and save Medicare funds by keeping out fraudulent providers in the first place. As the Dobson-DaVanzo report notes: "If CMS was to actively enforce that unlicensed providers cannot receive payment for providing orthotics and prosthetics services to Medicare beneficiaries within a licensure state, Medicare savings could be realized. Under such enforcement of limiting payments to providers with proven licensure and standards of training and experience, payments to unqualified providers would be eliminated. As the '60 Minutes' special suggested, allowing non-certified personnel to provide these services, especially in states with licensure, could lead to fraud and abuse in orthotics and prosthetics services, as well as expose patients who received these services to inappropriate or substandard care. Therefore, shifting payments to only certified providers could result in better care for beneficiaries and lower Medicare payments."

RAC Audits and the ALJ Appeals Backlog

Instead of using tools to keep bad actors from participating in the O&P sector, CMS has ramped up the Recovery Audit Contractor (RAC) program, which has had the effect of punishing legitimate providers.

While CMS makes payments to unlicensed and unaccredited providers, contravening Congress's intention, legitimate suppliers have been subject to RAC and prepayment audits conducted by contractors who appear to play by their own set of rules. It also appears that RAC audits penalize suppliers for paperwork or documentation errors as often, or more often, than it catches those perpetrating fraud. This sometimes results in legitimate providers, especially those who are small businesses, suffering cash flow problems or going out of business. AOPA estimates that roughly 100 O&P suppliers have gone out of business within the past eighteen months, at least in part due to these audit/recoupment related cash flow problems. The impact of these closings extends beyond economics and business—it directly and negatively affects individuals with limb loss, as they have been deprived of long-standing, clinically-beneficial relationships with their

health care providers. (We note that AOPA has sued the U.S. Department of Health and Human Services (HHS) over RAC audits and how they are being applied to O&P suppliers.)

We feel that certain actions by CMS have compromised the due process rights of O&P suppliers. For example, CMS issued a “Dear Physician” letter on its website in August, 2011 that had the effect of establishing new policy for payment for artificial limbs, and it applied the new policy retroactively in RAC and prepayment audits as to claims for dates of service as much as two years before the policy was issued in the letter.

There has been an explosion in the number of RAC audit claims under Medicare Part B for artificial limbs that are appealed to the Administrative Law Judge (ALJ) level. Congress and CMS have provided some modest relief for Medicare Part A providers, but none of this relief has been extended to Part B claims for artificial limbs. While we appreciate the difficult task facing the Office of Medicare Hearings and Appeals (OMHA), timely redress of improperly denied payments is critical. Many suppliers, particularly in the O&P field, are small businesses that do not have the luxury of waiting months for payment of services legitimately furnished. In fact, just last year, 35 Members of Congress wrote to HHS Secretary Kathleen Sebelius that well-intentioned efforts to reduce fraud and abuse in Medicare may be harming access for vulnerable Medicare beneficiaries and placing undue burdens on legitimate O&P providers. In a context of increasingly aggressive CMS audits, OMHA’s decision to suspend ALJ review of provider and supplier claims is devastating to suppliers who deliver Medicare services to over 40 million beneficiaries.

Congress showed that it understood the importance of timely processing of Medicare appeals when it included in BIPA a requirement that an ALJ issue a decision about a case within 90 days of the date when the appeal request was filed. However, by OMHA’s own admission, the current wait time for a hearing before an ALJ has increased to 16 months. In some areas that wait is as long as 26 months, which is unacceptable.

At the February 12, 2014 OMHA public hearing on this issue, Judge Griswold gave an explanation of OMHA’s position, but offered few if any short-term remedies that would restore the right of a timely ALJ hearing to providers. With ALJs siding fully with appellants in over half of all decisions, ALJ hearings amount to a provider’s primary means of challenging costly and often prejudicial CMS auditor decisions. As OMHA is leaving Medicare providers without an avenue of redress against auditors’ payment denials, we believe it is only fair that CMS suspend these audits until an appropriate, timely, and statutorily required system providing due process to providers is restored.

Surety Bonds Are Not an Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Impediment to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars. CMS’s imposition of surety bond requirements on all providers has been misdirected because it has little relationship to preventing

fraud. These bonds burden all O&P suppliers, disproportionately affecting small O&P suppliers, but they do nothing to distinguish legitimate supplier from fraudulent suppliers. Surety bond requirements are ineffective at preventing Medicare fraud and unnecessarily penalize legitimate providers.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that the Committee on Ways and Means Subcommittee on Health Ranking Minority Member, Rep. McDermott, has introduced a bill aimed at eliminating the exception to the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The Orthotic & Prosthetic Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results in an increase in the number and value of services that patients do not need. However, no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not an Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one, and in applying the concept to RAC audits, CMS has unfortunately only seen cookie-cutter models. Therefore, when CMS observes that a demonstration project in prior authorization is effective for power wheelchairs (PMD) in DME, it is inappropriate to simply believe the same approach will solve the O&P audit issues the same way. When applied to custom-fabricated O&P devices, prior authorization does not represent an improvement over the current RAC model for either providers or patients.

First, a major flaw is that Medicare Prior Authorization is NOT a promise of payment. Absent a payment guarantee, providers are subject to the same delays and denials currently imposed by RACs. Therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits.

A second major problem is that, in reality, the PMD demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees—who actually experience less delay under the current broken RAC regime. Prior authorization may have worked, but only for a few limited cases in the private sector, and only if it is an absolute guarantee of payment (otherwise, it creates its own cash flow problems). That is not true in Medicare. CMS would be severely challenged to implement prior authorization.

Recommendations for Reasonable Reforms of RAC and Pre-Payment Audits of Claims for Artificial Limbs for Beneficiaries under Medicare Part B

Following are proposals from the Orthotic & Prosthetic Alliance to reform RAC and prepayment audits of Part B claims for artificial limbs. These are steps that definitely would assist in restoring fairness, transparency and due process as well as greatly reducing the devastation RAC and prepayment audits by CMS contractors has caused Part B claims for artificial limbs for Medicare amputees. They include:

- a. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist;
- b. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier—the distinction between O&P and DME is clear both as O&P providers assume the role of lifetime mobility health professionals as well as being reflected in the much higher success rate when O&P appeals are decided at the ALJ level;
- c. Remove the Qualified Independent Contractor (QIC) stage of the appeals process, since it takes time and virtually never results in a favorable decision for the O&P provider;
- d. Advance the appeal more expeditiously to the ALJ for final action;
- e. Mandate that CMS compile data on audit appeals for O&P only, separate from DME which is needed to track both the very high rate O&P RACs audit appeals and high overturn rate on appeal (CMS has consistently refused to track such data)*;
- f. Establish financial penalties for RACs if an established percentage of appeal overturns occur, e.g. double interest penalties assessed against RAC, which funds along with savings from item C. above could be used to fund an increase in the number of ALJs; and
- g. Address the need for more ALJs to mitigate the current backlog, either by direction to the Office of Medicare Hearings and Appeals (OMHA), which as an arm of HHS is responsible for funding for ALJs, or a statutory change to allow CMS to fund ALJ appeals for RAC determinations.

* It was underscored in the May 20 hearing before the Oversight and Government Reform Committee that overturn rates at the ALJ level run between 56% to 74% provider success in overturning RAC audit conclusions.

CMS Should Issue a Moratorium on Part B RAC Audits

CMS should give serious consideration to halting RAC audits of Part B providers, especially for O&P providers. Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits and other questionable tactics to fight fraud and abuse continue unabated. We hope that this hearing shine the light also on the serious challenges faced by small providers without relief from RAC audits.

Many, including members of Congress, believe that the moratorium on RAC audits of short inpatient stays extends in some way to Part B claims for O&P. The truth is that there has been

no whatsoever from RAC audits for Part B providers. We urge CMS to implement a similar “pause” so that it can explore fully the effect on legitimate Part B providers.

Conclusion

In conclusion, AOPA will continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the O&P sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that prevents fraud before it starts, and we hope that Congress will direct CMS to implement relevant provisions contained in Section 427 of BIPA section 427 and that it will pass H.R. 3112.

AOPA appreciates the Committee’s efforts to work with us to find ways to better regulate our payments. We hope to continue to work with you to improve the quality of care we deliver to patients who need O&P services, and to protect the integrity of the Medicare program.



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STATEMENT SUBMITTED BY
THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
TO THE
HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
MAY 21, 2014

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 Energy and Commerce Subcommittee on Health reviews proposals to implement site of service Medicare payment reforms, 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 (PAC) that can both improve care for today's seniors and help 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 innovations and demonstration projects 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.

Significant health care delivery reforms are currently being tested that have the potential to alter how and where patients receive care. Overall, many of 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.

We believe the demonstration projects testing many new integrated care models and payment structures will provide valuable guidance on how to reform the post acute care system. We also appreciate that the “Bundling and Coordinating Post-Acute Care Act of 2014” (BACPAC) offers a model that adds to the dialogue on how to reform post acute care.

Below are several proposals that we believe could help achieve the evidence-based reform that realizes the promise of cost-effective, clinically appropriate care structures that avoid expensive institutional care.

a. Post-Acute Community Based Care Bundling: Improving Care Transitions and Maximizing PAC

We believe it is important that bundling arrangements for PAC allow PAC providers to hold and administer the risk-adjusted PAC benefit, not the acute care provider. The expertise related to managing patients in a post-acute setting lies with PAC providers, not hospitals, and the payment and accountability should be structured to reflect that. We are encouraged that CMS is testing a post-acute care bundling program where all provider payments are managed by home health agencies. We believe this will ultimately deter unnecessary re-hospitalizations, thus reducing administrative burden and cost. 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.

Given the evidence regarding the importance of involving home health providers early in the care transitions process, the most effective bundling model would integrate home health providers into the hospital discharge planning process upon the admission of a qualified patient to the hospital. The home health agency would be responsible for a comprehensive evaluation and PAC planning process that is designed to determine whether a patient is medically appropriate and feasible for discharge to the community.

Where the home health agency, in close coordination with the hospital, determines that community based care is not appropriate immediately upon hospital discharge, the responsibility for discharge to a post-acute inpatient setting is returned to the hospital. At that point, a post-acute inpatient care bundling may be triggered, if available.

With this model, the home health agency is responsible for any community-based care related to the patient’s inpatient treatment including home health services, physician services, outpatient rehabilitation services, and any intervening stay in an inpatient rehabilitation facility (IRF), long term care hospital (LTCH), or skilled nursing facility (SNF). Post-acute inpatient stays immediately following hospital discharge are outside of the home health agency responsibility.

Benchmarks could be based on existing measurements of quality and patient outcomes in combination with cost avoidance outcomes that relate to re-hospitalizations and use of emergent care.

Under a post-acute community based care bundling approach, providers would receive a case mix related per capita payment that is calculated on the basis of the combination of services in the bundle, adjusted for performance in a positive or negative manner.

One key aspect of making a bundled payment work is ensuring the technological means to share information among providers. Seamless care transitions depend on physicians, hospitals and home health agencies having access to patient information. The home care community has been an integral partner within the Standards and Interoperability (S&I) Community-Led Initiatives, such as the Longitudinal Coordination of Care (LCC) workgroup, to develop standards for interoperable transitions of care and care plans additions to the Consolidated Clinical Document Architecture (CCDA). Our goal is to leverage the support of these important editions to the CCDA to encourage the adoption of electronic health records (EHR) and also to support the interoperable exchange of health information that is the foundation for building new models of care delivery in home care.

b. Value-Based Purchasing Proposal: Improving Performance & Achieving Savings

MedPAC recommended application of a “pay for performance” system for home health and other Medicare provider payments. Starting in 2008, Medicare began the Medicare Home Health Agency Pay for Performance Demonstration project operating in seven states. Under the demonstration, home health agencies qualified for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending.

CMS shared more than \$15 million in savings with 166 home health agencies based on their performance during the first year of the Medicare Home Health Pay for Performance demonstration in 2009. Another \$15 million in savings was shared with the agencies in 2010.

As a result of the demonstration’s success, we believe that the Committees should consider authorizing a program that provides performance-based incentive payments to home health providers, taking into account readmissions rates and adherence to quality measures.

Unlike the CMS demonstration, the proposal we are putting forth contains both “carrots” and “sticks,” i.e. home health agencies will see reductions in reimbursements if quality metrics are not met. If implemented, we believe this proposal could produce \$2.5 billion in direct

savings over 10 years. The estimate is based on a CBO projected spend of \$250 billion between 2014 and 2023.

This estimate does not include the savings that the CMS demonstration showed would be generated from deterred inpatient services. We believe overall Medicare savings, outside of the direct savings we propose, would be at least \$600 million in the first year and more than \$7 billion over ten years. That is calculated roughly based on demonstrated savings from the CMS initiative. The Medicare Home Health Agency Pay for Performance Demonstration showed \$15M in savings with 166 HHAs. Currently, there are over 12,000 HHAs. If we conservatively assume that those HHAs generate a half of such savings, we would be looking at \$50,000 per HHA in 2014 X 12,000 HHAs= \$600M. Alternatively, if you assume that half of the HHAs garner equivalent savings to those in the demonstration it would come to the same dollar result. This estimate includes a small annual increase in savings due to the higher payments rates annually to hospitals, etc. and growth in Medicare enrollment.

We do not propose this value-based purchasing arrangement lightly, and given the drastic cuts in home health payments since 2009, we are hesitant about offering a payment withhold. However, we believe strongly that cuts must not be blunt or arbitrary. They must incentivize quality and maintain access to critical services for beneficiaries.

Proposal:

- Implement a 1.5 percent reduction in payments to skilled home health services over a 10 year period;
- Assess the total performance of a skilled home health provider using a methodology developed by the HHS Secretary and based on the Home Care Compare Hospital Rate and Emergent Care Rate established during the performance period, taking readmissions into account;
- Determine quality incentive payments for a skilled home health provider using the median performance score of all home health agencies, using a sliding scale such as:
 - Scores equal to or greater than 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent withheld plus an additional 1 percent payment;
 - Scores equal to or greater than median, but less than the 75 percentile nationwide would receive a quality incentive payment equal to the full 1.5 percent amount withheld plus an additional .25 percent payment;
 - Scores equal to or greater than the 25 percentile median, but less than the median score nationwide, would receive a quality incentive payment equal to 50 percent of the amount withheld; and
 - Scores below the 25 percentile shall not be eligible to receive a quality incentive payment and will have no opportunity to recoup the 1.5 percent cut.
- The Secretary should be given the opportunity to develop a waiver to ensure access to care, particularly for those living in health professional shortage areas.

Any legislative action in this area must be fair in its assessment of the quality of care provided to home health patients and incorporate pending changes to the OASIS assessment tool, as well as a mix of process and outcome measures. It should also be appropriately risk-adjusted and limit any expansion of data collection requirements and fully reimburse agencies for the costs of any additional data collection requirements that are imposed.

c. Telehealth Risk-Sharing Proposal: Reducing Inpatient Care through Technology

We believe that the use of telehealth should be a high priority as Congress considers evidence-based reform proposals to advance the nation on the fast track toward a highly functioning, technologically enabled, modernized health care delivery system. When deployed in the home as a service of home health care, remote patient monitoring technologies greatly enhance the cost savings potential of PAC. Seniors are able to remain in their homes longer, delaying costly transfers to higher acuity settings, are more engaged with their care and have higher levels of care satisfaction. Providers are able to better manage the care of patients with chronic conditions by monitoring changes in health status with increased frequency and employing advanced analytic tools and data trends to improve service delivery, care coordination and reduce unnecessary emergency room visits and hospital admissions.

These benefits have already been demonstrated in a number of home health agencies across the country. When telehomecare interventions for chronically ill Medicaid patients were deployed at Windsor Place Home Health in Windsor, Kansas, for example, hospital readmissions, emergency room visits and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period were approximately \$1.3 million, while the per patient cost of the intervention was just \$6 per patient per day. Similarly, at Forrest General Home Care and Hospice in Mississippi, targeted telehomecare interventions for patients with congestive heart failure and chronic obstructive pulmonary disease caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year.

We believe that results like those seen in Kansas and Mississippi could be experienced on a large scale if Medicare reimbursement policies supported the targeted use of telehealth in the home for both homebound patients and chronically ill patients who would benefit from “pre-acute” homecare.

To that end, we recommend that Congress consider legislation providing authority to CMS to test the value of care models that rely on the use of telehealth in home care settings.

One such bi-partisan legislative proposal is the Fostering Independence Through Technology Act of 2013 (S. 596), introduced by Senators Amy Klobuchar and John Thune. It

would provide authority for CMS to implement a shared savings pilot program for home care agencies using remote patient monitoring technology. Under this legislation, participating agencies would receive a 75 percent share of the total Medicare cost savings realized over a year relative to a performance target set by the Secretary of HHS. The legislation limits payments to the amount that would have otherwise been expended if the pilot project had not been implemented, making this proposal cost-neutral. This integration of telehealth combined with the use of health information technology would greatly modernize the service delivery of home health care and provide for additional cost savings.

d. Home-based Chronic Care Model – Integrated Care Model

The Home-based Chronic Care Model is a patient-centered, evidence-based model with care coordinated and supported across providers, sectors, and time. This model would benefit both homebound post-acute patients and pre-acute chronically ill patients. However, its real promise and source of cost savings lies in keeping chronically ill patients out of inpatient settings. The model is a partnership between home health agencies and patient centered medical homes that more fully treat the “whole” patient. The home health agency shares responsibility for patient outcomes with the primary care provider. The home health agency carries out the physician care plan and orders for guideline-level assessments and therapies (i.e. blood glucose monitoring, lipid analysis, flu and pneumonia vaccines.) The home health provider also conducts in-home health coaching, motivational interviewing and patient education, as well as provides ongoing support and monitoring.

Over time, the Home-based Chronic Care Model has evolved to incorporate new evidence, including a greater focus on patient empowerment and patient-centered care principles and methods to support care transitions. This model is now referred to as the “Integrated Care Model,” (ICM) as best practices are integrated into model tenets and care is integrated across providers and settings.

We encourage the Committees to look at integrated care models that include home health care at the center as a way to improve care and reduce costs. Following are three specific homecare agency results from implementing ICM as a care delivery model:

Baptist Health Home Health Network, Little Rock, Arkansas

The ICM program was initially implemented in one HHA in 2007. Specific outcomes in re-hospitalization rates and patient satisfaction were tracked over 2,000 patients. At this agency, re-hospitalization rates declined from 29 percent to 13 percent, and patient satisfaction increased from 93 percent to 97 percent the year following training. The ICCM model’s authors have described model focus areas, outcomes data, and lessons

learned in articles published in peer review journals (Suter, et al., 2008; Hennessey, et al., 2010), and this work was highlighted in a Joint Commission Case Study (2009).

FirstHealth Home Care , North Carolina

FirstHealth has embedded ICM best practices across a continuum of services in their system, including complex care management and telehomecare. Standardizing the delivery of care for patients with chronic disease led to the development of clinical pathways that incorporate the principles of ICM and also include use of the Patient Activation Measure and specific nutritional and therapy interventions for patients with heart failure, COPD, diabetes and cardiac surgery.

This approach has led to significant improvement in the home health hospitalization rate as well as the home health 30 day hospitalization rate as noted below: (fiscal year 2011, 2012 are October through September; 2013 is year to date October through June)

Home Health Hospitalization Rate (data not risk adjusted)

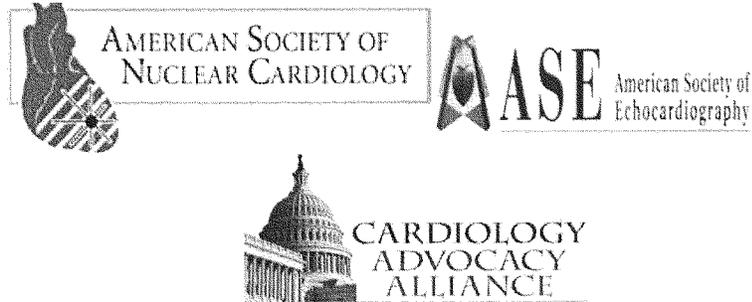
2011	26.47%
2012	23.87%
2013	20.76%

Home Health 30 day Re-hospitalization Rate (data not risk adjusted)

2011	17.41%
2012	16.92%
2013	10.85%

White County Medical Center Home Health , Searcy, Arkansas

The White County Medical Center Home Health trained all their clinical staff in ICM starting in 2011. They utilize ICM best practices in home care, care transitions, and for care coordination with other team members including physicians, pharmacists, and hospital case managers. Having a chronic care management program and requisite staff competencies has led to significant improvement in their acute care hospitalization (ACH) rates. The risk adjusted ACH rate has improved from 24.4 percent in June 2011 to 12.9 percent in April 2013. The agency is currently in the 1st percentile for the state rankings and 3rd in the nation for preventing acute care hospitalizations.



SITE NEUTRALITY: A Race to the Bottom for Patients with Heart Disease

On behalf of the American Society of Echocardiography (ASE), the American Society of Nuclear Cardiology (ASNC), and the Cardiology Advocacy Alliance, we thank you for the opportunity to submit this statement for the record in conjunction with the hearing – “Keeping the Promise: Site of Service Medicare Payment Reforms” – before the U.S. House of Representatives, Energy and Commerce Committee’s Subcommittee on Health, on Wednesday, May 21, 2014.

The concept of “site neutrality” is addressed in a number of MedPAC reports and in a number of contexts. In several of its reports, MedPAC has focused on disparities in Medicare payment among various providers of post-acute care (e.g. Skilled Nursing Facilities vs. Inpatient Rehabilitation Facilities), between hospital outpatient departments and physicians’ offices, and between hospital outpatient departments and ambulatory surgical centers. One option proposed by MedPAC would reduce Medicare payment for hospital outpatient services in 66 Ambulatory Payment Classifications (APCs) – hundreds of procedures and other services – to the levels paid in physicians’ offices or ambulatory surgical centers.

If adopted, this approach has the potential to devastate cardiology departments and patients with heart disease in hospitals throughout the country. These cuts would adversely impacting both inpatient and outpatient cardiac care provided to critically ill hospitalized patients as well as those served by hospital outpatient clinics. In fact, almost 50% of the Medicare payment reductions that would result from this proposal would hit hospital cardiology departments, reducing payment for nuclear cardiology procedures by almost 20% and reducing payment for cardiac ultrasound procedures by over 60%. These procedures are fundamental tools in the diagnosis of a broad range of cardiac disorders, including, for example, congestive heart failure, coronary artery disease, valvular heart disease, and congenital conditions.

We strongly oppose any policy that would reduce payment to hospital outpatient departments for cardiology services to the levels paid in physicians' offices:

- As MedPAC concedes, hospital outpatient services are already operating at a negative 11 percent margin, and adopting further outpatient payment reductions would deepen that deficit.
- MedPAC's own report on this issue notes that his policy would have a disproportionate, negative impact on small rural hospitals.
- This policy would redistribute \$1.1-\$1.3 billion among hospitals, with virtually no analysis of the potential unintended consequences.
- HOPPS is designed such that some procedures within a department may be overpaid and some underpaid, but, on average, the department is reimbursed based on its costs, as determined based on audited cost reports. Hospitals have unique expenditures not experienced by physician offices, including the requirement for 24/7 provision of care, the role as a safety net for patients unable to pay for services, and the costs associated with operating large scale integrated systems. These expenditures are not taken into account in

the Physician Fee Schedule methodology, which bases allowances on the resources required to provide services to the “typical” patient in a physician’s office.

- The patient populations served by hospital cardiology departments and physicians’ offices may be very different. For example, approximately 66% of cardiac ultrasounds performed by hospitals are provided to hospital inpatients, who are often critically ill, and more than 20% of these studies are provided in emergency rooms. The MedPAC proposal makes no adjustment to account for these differences in patient populations served by hospital cardiology departments and physicians’ offices.
- Because the Hospital Outpatient Prospective Payment (HOPPS) methodology differs in critical respects from the Physician Fee Schedule methodology, adopting the “site blind” policy proposed by MedPAC will result in illogical and unsupportable payment anomalies. For example, some physician services only have ‘global’ rates, which also include subsequent follow-up care following a procedure. As a result, the physician rates pay for a different bundle of services than the hospital APC, which results in an apples-to-oranges comparison between rates for the two settings.
- Services reimbursed under the HOPPS are placed in APCs on the basis of clinical and cost similarity, and all services within an APC have the same payment rate. On the other hand, physician services are paid on the basis of weights for the work, practice expense, and malpractice associated with an individual procedure, MedPAC proposes to reduce Medicare payment for *all procedures* in selected APCs based on physicians’ office rates based on whether *some of them* are paid less in physicians office settings: Thus, under MedPACs suggested policy, procedures in APCs could have their payments reduced even though those procedures are not, or not commonly, provided in the physician’s office.
- The proposed policy would result in unanticipated incentives for hospitals and physicians to substitute more costly –and potentially more invasive—procedures for those subject the “site blind” reductions.

Perhaps most importantly, the proposed policy has the potential to substantially reduce the quality of and impede patient access to critical cardiac services in our Nation's hospitals. Physician Fee Schedule allowances paid for the targeted cardiology procedures have been slashed to financially unsustainable levels, and reducing payment to hospital cardiology departments to these levels will inevitably impact patient care for those with heart disease.

The private practice of cardiology has been decimated by Medicare payment reductions that have been implemented under the Physician Fee Schedule over the past several years. For example, Medicare payment for the primary cardiac ultrasound service has been reduced by almost 50% since 2007 based in part on flawed data gathered from only 55 cardiologists throughout the country. As a result of these payment reductions and a leveling off in utilization, Medicare spending for cardiac ultrasound services under the Physician Fee Schedule was lower in 2011 than it was in 2001. These reductions have placed many cardiology practices under substantial financial constraints and threatened the independent practice of cardiology. Because of these reductions, there has been a drop in the number of physicians providing cardiac ultrasound services in their offices and an increase in hospital employment of cardiologists. It simply makes no sense to reduce payment for critical cardiac services provided by hospitals to levels that have already been determined to be insufficient. Quite simply, two wrongs don't make a right.

For further information, contact: Georgia Hearn (ASNC) - ghearn@asnc.org, or Peggy Tighe (ASE) - peggy.tighe@ppsv.com or Cathie Biga (CAA) CBiga@cardiacmgmt.com.

ASE is an organization of over 16,000 professionals committed to excellence in cardiovascular ultrasound and its application to patient care. ASE members include not only physicians but also cardiac sonographers who acquire cardiac ultrasound images for physician interpretation in both hospital and non-hospital settings.

ASNC is a greater than 4,500 member professional medical society, which provides a variety of continuing medical education programs related to nuclear cardiology, develops standards and guidelines for training and practice, promotes accreditation and certification within the nuclear cardiology field, and is a major advocate for furthering research and excellence in nuclear cardiology.

The Cardiology Advocacy Alliance (CAA) is a nonprofit organization that represents the interests of more than 5,000 cardiologists in the United States. CAA educates the professional cardiovascular community about regulatory and legislative issues that affect their ability to provide rapid access, high-quality patient care; represents the common interests of the cardiovascular patient and professional on such issues; and encourages its members to advocate for their patients and their practices.



Statement for the Record

Submitted by

The Premier healthcare alliance

House Energy and Commerce Subcommittee on Health

“Keeping the Promise: Site of Service Medicare Payment Reforms”

May 21, 2014

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record of the House Energy and Commerce hearing, titled “*Keeping the Promise: Site of Service Medicare Payment Reforms.*” Premier, Inc. is a leading healthcare improvement company, uniting an alliance of approximately 3,000 U.S. hospitals and 110,000 other providers to transform healthcare.

Among the more than 110,000 alternative care sites in the Premier alliance are skilled nursing facilities, home health agencies, rehabilitation centers and long-term acute care facilities. Together, Premier’s hospitals, post-acute care sites and other providers are seeking better ways to reduce the fragmentation of healthcare and increase coordination of care. Premier operates a number of large-scale collaboratives, including those focused on bundled payment and accountable care organizations (ACOs), in which Premier health systems push for improved quality at a reduced cost.

We applaud the leadership of Chairman Rep. Joe Pitts and Ranking Member Frank Pallone, Jr. for holding this important hearing. While there are many initiatives our alliance members can undertake on their own to improve the quality, safety and affordability of healthcare, continued government action is needed to fix perverse payment incentives and foster greater coordination of patient care.

Aligning incentives across the continuum of care through bundled payments

The current fee-for-service (FFS) payment system impedes healthcare providers' attempts to achieve high-quality and cost-effective healthcare. Premier believes that one promising approach that breaks down the existing silos of care, aligns providers' incentives and encourages greater coordination is bundled payment. Because of the goal of coordinating care, bundled payments can include participation by multiple provider types across the continuum of care. We believe it is critical to include the full continuum of care across payment silos to improve patient outcomes and achieve better value. Bundling post-acute care payment systems alone will not achieve the transformations that patients, providers and the government are seeking.

Post-acute care bundling can be a valid and appropriate option for certain episodes of care. However, a post-acute care bundled payment model based on hospital-related conditions that does not include the hospital stay in the bundle is similar to constructing a building without starting with the foundation. For episodes that start with a hospital stay, such as hip/knee joint replacement, the episode should include the hospital stay and a time prior to hospitalization. In such cases, poorly executed transitions from a hospital to another site of care can place beneficiaries at risk for a rehospitalization that is undesirable for both the beneficiary and the program. If hospitals continue to be held accountable for patients after they transition to another site of care and post-acute care sites are accountable for any return to the hospital or admittance to another post-acute care facility, it will incentivize better coordination and could help prevent otherwise avoidable and potentially costly readmissions. For example, bundled payment that includes both post-acute and acute care could encourage a hospital to operate a nurse call line to provide assistance for patients which could, in turn, prevent readmissions to a skilled nursing facility.

The Medicare Payment Advisory Commission (MedPAC) identified a number of advantages to bundling payments for combined hospital-post-acute care, including encouraging care coordination between providers, encouraging more efficient resource use across an episode of care and narrowing the wide variation in post-acute care spending. Specifically, in the June 2013 report to Congress, MedPAC noted that a post-acute care-only bundled payment model may not achieve the levels of care coordination of larger hospital plus post-acute care bundles because providers would have fewer incentives to coordinate care between the hospital and the PAC settings. In addition, the commission noted that post-acute care providers could encourage physicians and discharge planners to refer beneficiaries to post-acute care, which could generate unnecessary care. Commissioners also discussed that improved care coordination could result in better and fewer care transitions between settings, lower risk of readmissions, and less time elapsed between hospital discharge and post-acute care admission.

Advancing bundled payments through a permanent, national program

The concept of bundled payments is not new, and has in fact already been tested by the Centers for Medicare & Medicaid Services (CMS) through the Acute Care Episode Demonstration, among other programs, and such arrangements are successfully operating in the private sector. Premier members have participated in these programs, as well as the Center for Medicare & Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative that is currently underway. However, we believe it is time to move beyond pilot programs and implement a broad-scale, voluntary bundled payment program that is available to providers nationwide on a permanent basis.

With the investment of time and resources needed to implement bundled payments, providers can be reluctant to engage in these transformative efforts because of uncertainty about whether such payment systems will ever be deployed widely. The enactment of a national, voluntary bundled payment program would provide certainty to providers by placing a stake in the ground, signaling that Congress and CMS are dedicated to improving quality and safely reducing costs for Medicare beneficiaries through such a mechanism. This will assure providers that bundled payment is not a passing fad, but one they can invest in for the long term.

With sustained diligence and oversight by Congress to advance models such as bundled payments that create incentives for efficiency and better care coordination, we are confident that we will continue on the path toward higher quality care while bending the cost curve

Mr. PITTS. Did you have a UC request?

Mr. PALONE. Mr. Chairman, I would ask unanimous consent to include this A. Dobson/DaVanzo study titled "Assessment of Patient Outcomes."

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities and After Discharge

Study Highlights

Authors: Joan E. DaVanzo, Ph.D., M.S.W., Al Dobson, Ph.D., Audrey El-Gamil, Justin W. Li, Nikolay Manolov, Ph.D.
 Contact: Joan E. DaVanzo, joan.davanzo@dobsondavanzo.com; 703-260-1761

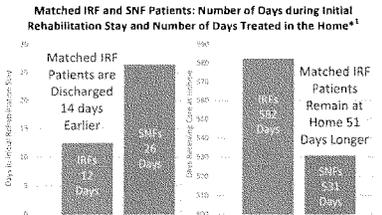
Synopsis of Key Findings

We found that patients treated in IRFs had better long-term clinical outcomes than those treated in SNFs following the implementation of the revised 60% Rule. We used Medicare fee-for-service claims data to compare the clinical outcomes and Medicare payments for patients who received rehabilitation in an inpatient rehabilitation facility (IRF) to clinically similar matched patients who received services in a skilled nursing facility (SNF).

- Over a two-year study period, IRF patients who were clinically comparable to SNF patients, on average:¹
 - Returned home from their initial stay **two weeks earlier**
 - Remained home nearly **two months longer**
 - Stayed alive nearly **two months longer**
- Of matched patients treated:²
 - IRF patients experienced an **8% lower mortality rate** during the two-year study period than SNF patients
 - IRF patients experienced **5% fewer emergency room (ER) visits per year** than SNF patients
 - For five of the 13 conditions, IRF patients experienced **significantly fewer hospital readmissions per year** than SNF patients
- Better clinical outcomes could be achieved by treating patients in an IRF with an additional cost to Medicare of \$12.59 per day (while patients are alive during the two-year study period), across all conditions.³

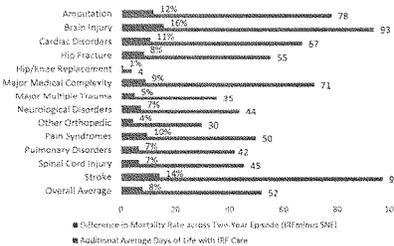
- This study serves as the most comprehensive national analysis to date examining the long-term clinical outcomes of clinically similar patient populations treated in IRFs and SNFs, utilizing a sample size of more than 100,000 matched pairs drawn from Medicare administrative claims.
- The focused, intense, and standardized rehabilitation led by physicians in IRFs is consistent with patients achieving significantly better outcomes in a shorter amount of time than patients treated in SNFs.

IRF patients are matched on demographic and clinical characteristics, and rehabilitation in IRFs leads to longer surviving, fewer readmissions and ER visits, and more days at home (not in a hospital, IRF, SNF, or LTCH) than rehabilitation in SNFs for the same conditions. This suggests that the care delivered is not the same between IRFs and SNFs. Therefore, different patient-care settings affect patient outcomes.



*Days treated in the home represents the average number of days per patient over two-year study period not spent in a hospital, IRF, SNF, or LTCH.

Matched IRF and SNF Patients: Difference in Mortality Rate³ across Two-Year Study Period and Resulting Additional Days Alive⁴ During Episode*



*Difference in the mortality rate of matched IRF patients to matched SNF patients over the two-year study period. As a result of the lower mortality rate, additional average days of life represent the difference in the average episode length (after accounting for mortality) across groups (IRF average episode length in days minus SNF).

¹ Differences are statistically significant at p<0.0001.

² Differences are statistically significant at p<0.0001 with the exception of the number of readmissions per year, which are significant at p<0.01 for five of the 13 conditions.

³ Differences are statistically significant at p<0.0001 with the exception of major multiple trauma, which is significant at p<0.01.

The Issue

To qualify for Medicare payment under the IRF prospective payment system (PPS) at least 60% of an IRF's admissions in a single cost reporting period must be in one or more of 13 CMS specified clinical conditions ("known as the "60% Rule").¹ As a result of this policy, some Medicare beneficiaries with certain conditions previously treated in the IRF are now treated in an alternative setting, such as a SNF. The Medicare Payment Advisory Commission (MedPAC) found, for instance, that the proportion of IRF patients treated for lower joint replacements decreased by 16%, while SNF admissions of this diagnosis increased by the same rate between 2004 and 2011.²

There is a significant difference in medical rehabilitation care practices between the two settings.³ Treatment provided in IRFs is under the direction of a physician and specialized nursing staff.⁴ Care plans are structured, focused, and time sensitive to reflect the pathophysiology of recovery, avoid patient deconditioning, and maximize potential functional gain. On the other hand, SNFs exhibit greater diversity in practice patterns with lower intensity rehabilitation,⁵ possibly due to limited presence of an onsite physician and no regulatory rehabilitation standards.

The implication of the 60% Rule on long-term beneficiary health outcomes and health care utilization has not been thoroughly investigated.

Despite limited information concerning the rule's effect on beneficiaries, policymakers are considering revisions to IRF payment policy. One revision would raise the current compliance threshold from 60% to 75%, a more restrictive standard. Under a second proposal, MedPAC is developing a recommendation to reduce the difference in Medicare payments between IRFs and SNFs by reimbursing IRFs the SNF payment rate for three specific clinical conditions, some of which are included in the 13 conditions under the 60% Rule: major joint replacement without complications or comorbidities (CC), hip fracture with CC, and stroke with CC.

About the Study

The ARA Research Institute (an affiliate of the American Medical Rehabilitation Providers Association – AMRPA) commissioned Dobson DaVanzo & Associates, LLC to conduct a retrospective study of IRF patients and clinically similar SNF patients to examine the downstream comparative

Conclusions to Date

- The care provided in IRFs and SNFs differs, as patients treated in IRFs experienced different outcomes than matched patients treated in SNFs.
- Patients treated in a SNF as a result of the 60% Rule who could have otherwise been treated in an IRF might be adversely affected by an increased risk of death, increased use of facility-based care, and more ER visits and hospital readmissions.
- Confirmation or expansion of the 60% Rule or altering the payment across the SNF and IRF PPSs without understanding the impact on patient outcomes in IRF admitted and could negatively impact Medicare beneficiaries.

utilization and effectiveness of post-acute care pathways, as well as total cost of treatment for the five years following implementation of the 60% Rule.

Using a 20% sample of Medicare beneficiaries, this study analyzed all Medicare Parts A and B claims across all care settings (excluding physicians and durable medical equipment) from 2005 through 2009. Patient episodes were created to track all health care utilization and payments following discharge from a post-acute rehabilitation stay in an IRF and a SNF. Patients admitted to an IRF following an acute care hospital stay were matched to clinically and demographically similar SNF patients. Patient outcomes were tracked for two years following discharge from the rehabilitation stay. This study period allowed us to capture the long-term impact of the rehabilitation, including meaningful differences in mortality, use of downstream facility-based care, and patients' ability to remain at home.

To aid in the interpretation and clinical validation of this analysis, the Dobson | DaVanzo team worked with a clinical expert panel comprised of practicing post-acute care clinicians.

Study Limitations

Medicare fee-for-service claims do not include care covered and reimbursed by Medicaid and third-parties or detailed clinical information. Therefore, non-Medicare services, such as long-term nursing home stays, are not captured in this analysis. This omission may have overestimated the calculated number of days a patient remained at home, and underestimated the cost of their health care to the federal and state governments.

Additionally, the results of this study are not generalizable to the universe of SNF patients within the studied clinical conditions. Analyses suggest that SNF patients who are clinically similar and matched to IRF patients have different health care utilization and Medicare payments than those who were not matched.

¹ The compliance threshold was originally set at 75% and was to be phased in over a three-year period, but compliance was capped at 60% following the Medicare, Medicaid, and SCHIP Extension Act of 2007. While the policy has retained its namesake at the "75% Rule" despite the cap at 60%, this study refers to it as the "60% Rule".

² Medicare Payment Advisory Commission (MedPAC). 2013. *Report to Congress: Medicare Payment Policy*. Washington, D.C.

³ Keith RA. (1997). Treatment strength in rehabilitation. *Arch Phys Med Rehabil*. 90: 1269-1283.

⁴ Harvey RL. (2010, January). Inpatient rehab facilities benefit post-stroke care. *Managed Care*.

⁵ Debing S, Hsieh C, Cassaway J, et al. (2009). Characterizing rehabilitation services for patients with knee and hip replacement in skilled nursing facilities and inpatient rehabilitation facilities. *Arch Phys Med Rehabil*. 90: 1269-1283.

Mr. PITTS. Dr. Burgess, do you have a UC request?

Mr. BURGESS. Yes, Mr. Chairman, I ask unanimous consent that joint testimony of the American Society for Echocardiology, the American Society of Nuclear Cardiology and the Cardiology Advocacy Alliance be submitted for the record.

Mr. PITTS. Without objection, so ordered.

We have two panels before us today. On our first panel, we have Mr. Mark Miller, Executive Director of the Medicare Payment Advisory Commission. Welcome. Thank you for coming. Your written testimony will be made part of the record, and you will be recognized for 5 minutes to summarize. So at this point, the Chair recognizes Mr. Miller for 5 minutes.

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

Mr. MILLER. Chairman Pitts, Ranking Member Pallone, distinguished members of the committee, thank you for asking the Commission to testify today.

As you know, Congress created MedPAC to advise it on Medicare issues, and today I have been asked to comment on site-neutral and other payment reforms for post-acute care in ambulatory settings.

The Commission's work in all instances is guided by three principles: to assure that beneficiaries have access to high-quality, coordinated care; to protect the taxpayers' dollars and to pay providers and plans in a way to accomplish these goals.

First, some of the problems that we face. Fee-for-service encourages fragmented care because we pay on the basis of location or provider rather than the beneficiary's episodes of needs. Fee-for-service also encourages high volume of service. We know that Medicare payment rates send signals, and if they are set too high or constructed inconsistently across setting, they can result in patient selection or care patterns that focus on revenue rather than patient needs.

Post-acute care has an additional issue. The clinical guidelines regarding when a service is needed are often poorly defined and it is hard to know when an episode should begin and when an episode should end.

With respect to ambulatory care, the last few years of data shows that hospitals are aggressively purchasing physician practices, and the Commission is concerned that part of the motivation is that they can bill for the same service at a higher hospital payment rate resulting in more trust fund expenditures and higher out-of-pocket for the beneficiary but no change in the service provided.

So what has the Commission's guidance been? In the short run, in focusing in some instances or in a lot of instances on fee-for-service, the Commission would set all fee-for-service payment rates to reflect the cost of the efficient provider. This protects the taxpayer and also protects beneficiaries' premiums that support the program. Of particularly urgent attention are the very high rates in home health and skilled nursing facility settings that have been set high for over a decade. The Commission would set fee-for-service payment rates to be the same or similar for similar patients

and similar services. This protects the taxpayer, and again, if there is cost-sharing, it protects the beneficiaries' out-of-pocket.

As part of a broader recommendation on hospitals that included an update, the Commission recommended setting payment rates for selected patients the same for long-term-care hospitals and acute-care hospitals and also recommended that payment rates for a selected set of outpatient services be set equal to or near the physician fee schedule.

In order to protect the hospital's core mission, these services were chosen because they are frequently done in a physician's office, they are not part of the hospital's emergency standby services, and they are used by patients with comparable risk profiles.

Just focusing on three services. If continued migration that we see in the data now, or if migration continues as we see in the data now, by 2021, the program will be paying \$2 billion more on an annual basis for just these three services, of which \$500 million would be paid by the beneficiary.

The Commission is also exploring policies to normalize payment rates between skilled nursing facilities and inpatient rehab facilities. That work is developmental and will be published in the June report, but I am happy to take questions on it.

We have also been concerned that the payment systems are set to encourage patient selection. We have longstanding recommendations in skilled nursing facilities and home health settings to take down the incentives to see physical-rehab patient and avoid complex medical patients. We think this protects the beneficiary against patient selection and it protects providers that take the more complex patients.

The Commission would also create policies to encourage coordination. We have recommended penalties for hospitals, skilled nursing facilities and home health agencies that have excessive readmission rates. This protects the beneficiary by encouraging care coordination and of course the taxpayer from paying for unnecessary care.

In the longer run, the Commission has called on CMS to create pilot projects to develop various bundling payment strategies for acute and post-acute care and has called for the development and implementation of a common assessment for post-acute care. This would allow us to consistently assess patient needs, to track their change in functional status and quality, and to move towards a unified payment system on the post-acute care side. Beyond fee-for-service, a well-functioning managed care program and initiatives like the accountable care organizations can also create incentives to avoid unnecessary volume and coordinate services for providers. The Commission has a broad range of guidance on each of these, and we are willing to take questions on that as well.

In closing, the Commission has consistently tried to make policy recommendations that assure beneficiary access to coordinated care at a price that the taxpayer can afford.

I appreciate your attention and I look forward to your questions.
[The prepared statement of Mr. Miller follows:]

**Medicare Fee-For-Service
Payment Policy Across Sites of Care**

May 21, 2014

Statement of

Mark E. Miller, PhD

Executive Director

Medicare Payment Advisory Commission

Before the

Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

Chairman Pitts, Ranking Member Pallone, 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 the Commission's views of Medicare payment policies across different sites of care.

The Medicare Payment Advisory Commission is a Congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.

Introduction

The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers fairly, rewards efficiency and quality, and spends tax dollars responsibly. When we examine Medicare's payment policies across different sites of care, we observe several opportunities for policy development. In the testimony that follows, I will present the Commission's work on price differences across settings for ambulatory care and post-acute care (PAC), as well as the use of standard patient assessment tools and other payment policies to encourage care coordination in PAC.

In other Commission products, we provide important information and recommendations about setting payments in Fee-For-Service (FFS) Medicare to the level of the efficient provider and revising the payment systems to make them more equitable among providers.

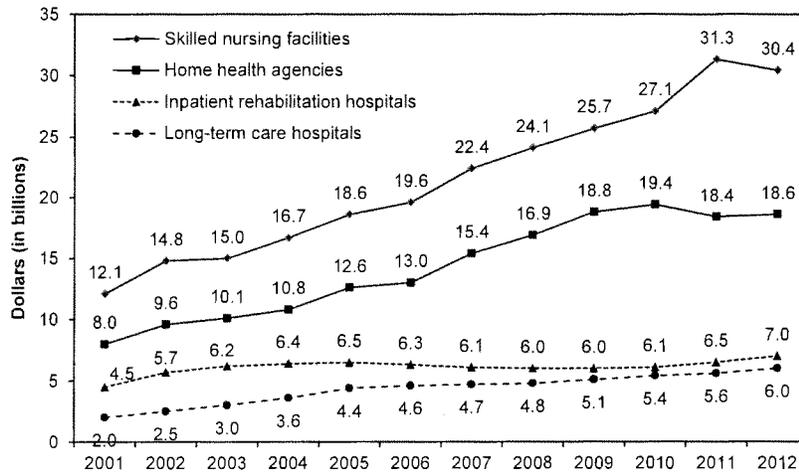
Background on post-acute care

Post-acute care providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). As with any service, the Commission's goal is to recommend policies related to payments for PAC providers that ensure beneficiaries receive medically necessary, high-quality care in the least costly setting appropriate for their condition.

In 2012, about 41 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting. Of those, half went to SNFs, 39 percent received

home health care, and the remainder went to other settings, including IRFs and LTCHs. While almost all beneficiaries admitted to SNFs, IRFs, and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the community. In 2012, PAC FFS spending totaled \$62 billion and accounted for 17 percent of FFS spending. As shown in Figure 1, spending has increased for each PAC setting, with total PAC FFS spending more than doubling from 2001 to 2012. Over the same period, per beneficiary PAC FFS spending more than doubled as well.

Figure 1. Medicare's total FFS 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.

The Commission has repeatedly noted the shortcomings of Medicare's FFS payment systems for PAC and the clear need for reforms. In many cases, payments are set too high relative to providers' cost to treat Medicare patients. High Medicare margins and rapid entry of certain PAC providers into the program over the last decade are indications of potential financial opportunity in Medicare. Furthermore, the PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability. Although CMS has adopted

setting-specific rules to delineate the types of patients appropriate for IRFs and LTCHs, there is overlap in the types of patients treated in different settings. Because Medicare pays significantly different rates across settings, treating similar patients in different settings can unnecessarily increase program spending.

Though Medicare payments for PAC must be reformed, making improvements is challenging for several reasons. First, the need for PAC is not well defined; some patients can go home from the hospital without it, while others need it but receive varying amounts of service in different settings. Still others remain in the acute care setting a few days longer and avoid PAC altogether. The amount and type of PAC a patient receives is highly dependent on providers' practice patterns. While Medicare rules (conditions of participation and payment and coverage rules) provide some guidance regarding placement in PAC, providers of PAC have considerable latitude in terms of which patients they admit among the patients referred to them by hospitals. The Commission and others have documented the similarity of patients treated in different PAC settings. Reflecting this ambiguity, Medicare service use (as measured by per-capita spending adjusted for prices and health status) of PAC varies more than most other covered services. Service use in the geographic area at the 90th percentile is more than twice that of the area at the 10th percentile for PAC, while it is only about 20 percent higher for acute inpatient and ambulatory service use. At the extremes, PAC utilization varies by nearly a factor of eight. The range in service use indicates opportunities for more effective purchasing of PAC services by the Medicare program (Table 1).

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.

Second, PAC providers treat similar types of patients, yet Medicare pays different prices depending on the setting. For example, patients recovering from strokes and hip replacements are treated in IRFs and SNFs, but Medicare's payments per stay to IRFs are 25 to 40 percent higher than its payments to SNFs for these conditions.

Further complicating reform efforts are utilization patterns that do not reflect efficient care. There are no financial incentives for hospitals to refer patients to the most efficient or effective setting, so actual PAC use does not indicate where patients would best receive their care or how much care is optimal. Instead, placement decisions can often reflect the availability of PAC settings in a local market (and whether there is an available bed), the hospital's and family's 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 with whom it contracts).

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.

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).

Given the wide variation in spending and service use, it is critical that Medicare and its beneficiaries compare the efficacy of services provided in different settings. The Commission has discussed policy options in three areas to align Medicare policy across settings in post-acute care: (1) using a standardized assessment tool, (2) establishing site neutral payments across PAC settings, and (3) applying similar incentives across settings for care coordination.

Standardized Assessment Tool

Medicare requires three of the PAC settings (HHAs, SNFs, and IRFs) to use setting-specific patient assessment tools in determining a patient's resource requirements. Although the tools cover similar information areas, each tool asks different questions, defines the activities being assessed differently, uses different scales to gauge patient functional status, and assesses patients over varying time frames. LTCHs are not required to submit comprehensive patient assessment information at admission and discharge.

The lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. Furthermore, without comparable information, we cannot systematically evaluate the cost and outcomes of the care that beneficiaries receive across settings. Providers may look more efficient or more able to achieve better outcomes, when actually, they treat less complex cases. Adequate risk adjustment is critical to making fair comparisons across providers and giving beneficiaries accurate information about high-quality providers. Common assessment items would gather comparable outcomes data to enable adjusting payments and outcomes to reflect differences across patients. Knowing which sites produce the best outcomes for each condition could be used to inform PAC placement decisions

and could possibly serve as evidence for Medicare to refine its coverage policies for these services.

Despite the need for standardized information across PAC settings, the Medicare program has been slow to implement the collection of common assessment information. In 1999, MedPAC called for the Secretary of Health and Human Services (HHS) to collect a core set of patient assessment information across all PAC settings. In 2005, the Deficit Reduction Act required a demonstration to develop and test a tool to collect that information. Medicare successfully developed, validated, and tested a tool called the Continuity Assessment Record and Evaluation (CARE) tool, and this process demonstrated its feasibility and acceptability. The results of this demonstration were reported to the Congress in 2012. Given these findings, and the urgency of moving forward with payment reforms, the Commission has recommended that Congress direct the Secretary to implement common patient assessment items for use in HHAs, SNFs, IRFs, and LTCHs by 2016.

Reforms to eliminate price differences across sites of care

As mentioned above, providers treat similar types of patients, yet Medicare pays different prices depending on the site of care. The Commission holds that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Within PAC, the Commission has focused on payment differences between SNFs and IRFs, and LTCHs and acute care hospitals. In each case, the Commission has developed a set of criteria to identify patients with similar care needs to guide the establishment of payment policy.

Patients with similar care needs in SNFs and IRFs

Two PAC settings where certain groups of patients with similar care needs are treated are SNFs and IRFs. In the forthcoming *June Report to Congress*, the Commission compares Medicare payments for three conditions frequently treated in both settings. Because there is some overlap in the patients treated in both settings, yet payments can differ, there is a need to develop site-neutral policies that eliminate unwarranted payment differences. The Commission is not alone in

its interest in aligning payments between IRFs and SNFs. Since 2007, administrations' proposed budgets under presidents from both parties have included proposals to narrow prices between IRFs and SNFs for select conditions commonly treated in both settings.

The services typically offered in IRFs and SNFs differ in important ways. IRFs are required to meet the conditions of participation for acute care hospitals, including having more nursing resources available and having care supervised by a rehabilitation physician, among other requirements. Stays in IRFs are shorter on average and patients in IRFs receive more intensive services, in part because patients admitted must be able to tolerate and benefit from an intensive therapy program. The Commission recognizes that the services in the two settings differ; rather, it questions whether the program should pay for these differences when the patients admitted, and the outcomes they achieve, are similar.

Using several criteria, we selected three conditions frequently treated in IRFs and SNFs—patients receiving rehabilitation therapy after a stroke, major joint replacement, and other hip and femur procedures (such as hip fractures)—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We examined the characteristics of patients admitted to SNFs and IRFs and did not find large differences, especially for the orthopedic conditions, but there was more variation across the stroke patients. There was considerable overlap of risk scores, ages, comorbidities, functional status at admission, and predicted costs for therapy and nontherapy ancillary services (such as drugs). The average functional status at admission and patients' comorbidities overall did not differ substantially and the two settings admitted similar shares of dual-eligible and minority beneficiaries.

Differences in outcomes between IRFs and SNFs were mixed: unadjusted measures showed larger differences between the settings, and risk-adjusted measures generally indicated small or no differences between the settings. IRFs had lower observed readmission rates compared with SNFs for the three conditions, but with risk adjustment, CMS analysis found no statistically significant differences between the sites in rates of rehospitalization or changes in mobility. The unadjusted mortality rates during the 30 days after discharge were higher for patients who went to SNFs compared with patients who went to IRFs. Spending in the 30 days after discharge was higher for IRF patients than for SNF patients, due primarily to higher spending on other PAC

services such as SNF and home health care.

For the three conditions, we found that if IRFs were paid at the SNF rates, their aggregate payments for the three select conditions would decline. The industry-wide impact on total payments could be mitigated because IRFs would continue to receive IRF payments for the majority of their cases. The site-neutral policy could also be structured to maintain the add-on payments many IRFs receive for the select conditions. The impact of this policy was consistent across different types of IRFs (e.g., for-profit, non-profit). Although certain types of providers have higher shares of site-neutral cases, they also tend to have higher add-on payments that dampen the impact of a site-neutral policy.

If payments for select conditions were the same for IRFs and SNFs, the Commission believes that Medicare should consider waiving certain regulations for IRFs when treating site-neutral cases to level the playing field between IRFs and SNFs. Waiving certain IRF regulations would allow IRFs the flexibility to function more like SNFs when treating comparable cases.

Selecting a handful of conditions to study allowed us to explore potential for site-neutral payments between IRFs and SNFs. We found that the patients and outcomes for the orthopedic conditions were similar and represent a strong starting point for a site-neutral policy. Patients receiving rehabilitation care after a stroke were more variable, and we conclude that additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral policy and those that could be excluded from it.

Care for Chronically Critically Ill Patients in LTCHs and Acute Care Hospitals

Care for chronically critically ill patients is a second area of care within PAC where the Commission has observed patients with similar care needs receiving care in different settings. LTCHs have positioned themselves as providers of hospital-level care for long-stay chronically critically ill (CCI) patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI.

Medicare pays LTCHs under a separate PPS, with higher payment rates than those made for similar patients in the acute care hospital. There are few criteria defining LTCHs, the level of

care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less-expensive settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not CCI.

The effect of the disparity in Medicare's payments across settings for the most medically complex patients is exacerbated because such cases often are unprofitable in acute care hospitals paid under the IPPS. In areas with LTCHs, acute care hospitals may be able to reduce the costs of caring for some types of cases by transferring them earlier in the course of illness. In areas without LTCHs, acute care hospitals may have to keep these cases longer—and therefore accrue additional costs—until the patients are stable enough to be transferred to a lower level of post-acute care.

The Commission has raised questions about what Medicare is purchasing with its higher LTCH payments. Studies comparing LTCH care with that provided in acute care hospitals have failed to find a clear advantage in outcomes for LTCH users. At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. In addition, some studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill.

The Commission's approach to reforming the LTCH PPS and aligning payment for CCI cases across settings is based on the premise that the most medically complex patients have always been a small share of the total population of hospital inpatients. Although hospital case mix has increased over time, the explosive growth in the number of LTCHs that followed implementation of the PPS was not driven by a need for these services but rather by payment policies that created opportunities for financial gain.

To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended in our March 2014 *Report to Congress* that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI would be paid acute care hospital rates approximately the same as MS-

DRG payment rates they would have been paid if the patient had been treated in an acute care hospital in the same local market. Funds that would have been used to make payments under the LTCH payment system instead should be allocated to the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals.

The Commission recommends that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. The Commission also recommended that an exception to the eight-day ICU threshold be made for LTCH cases that received mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher LTCH-level payment rates.

Reforms that promote care coordination

Over the last several years, Medicare has begun moving towards paying providers differentially for the quality of care they provide and the success of their care coordination efforts. The efforts began with a focus on inpatient hospitals and have begun to expand to other provider types. If value-based payment policies are not applied to all providers who are involved in treating Medicare patients, Medicare may not achieve the quality or care coordination outcomes it desires.

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. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions.

In 2011, the Commission began to examine expanding readmission policies to PAC settings to reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC 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 that

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 twice as high as episodes without them. 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.

To increase the equity of Medicare's policies towards providers who have a role in care coordination, the Commission has recommended payments be reduced to both SNFs and HHAs with relatively high risk adjusted readmission rates. The proposed readmissions reduction policies would be based on providers' performance relative to a target rate. Providers with rates above the target would be subject to a reduction in their base rate, while agencies below would not. Such an approach could encourage a significant number of agencies to improve, thereby achieving savings for the Medicare program through penalties and lower hospital readmissions. The proposed policies also seek to establish incentives for all providers to improve, without penalizing providers that serve significant share of low-income patients. To do so, providers' performance would be compared to other providers that serve a similar share of low-income patients.

The SNF readmissions reduction program was recommended in the Commission's March 2012 *Report to Congress*. In March 2014, as part of the Protect Access to Medicare Act of 2014, the Congress enacted a SNF value-based purchasing program beginning in fiscal year (FY) 2019,

which includes readmissions and resource use measures. The home health readmissions reduction program recommendation was published in the March 2014 *Report to Congress*.

Bundled payments

Under bundled payments, Medicare would pay an entity for providing an array of services to a beneficiary over a defined period of time. In the case of PAC, the bundle could cover all PAC services following a hospitalization. This would put pressure on all the PAC providers involved in providing care an incentive to provide high quality care in the most efficient setting.

Given the wide variation in PAC use, such an approach could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments could also give providers that are not ready or unable to participate in more global payment like 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. In our June 2013 *Report to the Congress*, the Commission described 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.

Background on ambulatory payment systems

Ambulatory care refers to medical services performed on an outpatient basis, without admission to a hospital or other facility. Ambulatory care is provided in settings such as ambulatory surgical centers (ASCs), hospital outpatient departments (OPDs), and the offices of physicians and other health professionals. Medicare generally covers ambulatory care under Part B, but pays for it using setting-specific payment systems.

Payment rates often vary for the same ambulatory services provided to similar patients in different settings. Medicare sets payment rates for physician and other practitioner services in the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS); payment rates for most OPD services in the outpatient prospective payment system (OPPS); and payment rates for ASC services in the ASC payment system.

When a service is provided in a practitioner's office, there is a single payment for the service. However, when a service is provided in a facility, such as an OPD or ASC, Medicare makes a payment to the facility in addition to the payment to the practitioner. For example, if a 15-minute evaluation and management (E&M) office visit for an established patient is provided in a freestanding practitioner's office, the program pays the practitioner 80 percent of the PFS (nonfacility) payment rate and the patient is responsible for the remaining 20 percent. If the same service is provided in an OPD, the program pays 80 percent of the PFS (facility) rate and 80 percent of the rate from the OPPS and the patient is responsible for 20 percent of both rates. As a result, Medicare typically pays much more when services are performed in an OPD, and the beneficiary has higher cost sharing. For example, in 2014 both the program and the beneficiary paid 116 percent more in an OPD than in a freestanding office for a level II echocardiogram.

Payment variations across settings need immediate attention because the billing of many ambulatory services has been migrating from freestanding offices to the usually higher paid OPD setting. Among E&M office visits, echocardiograms, and nuclear cardiology services, for example, the volume of services decreased in freestanding offices and increased in OPDs from

2010 to 2012 (Table 3). For example, the volume of echocardiograms in freestanding offices dropped by 9.9 percent from 2010 to 2012 but grew by 33.3 percent in OPDs. One of the factors driving this phenomenon is the rapid growth in hospital purchases of physician practices. According to data from the American Hospital Association Annual Survey of hospitals, the number of physicians and dentists employed by hospitals grew by 55 percent from 2003 to 2011. As billing of services shifts from freestanding offices to OPDs, program spending and beneficiary cost sharing increase without significant changes in patient care. To limit the incentive to shift cases to higher cost settings, there is a need to align OPD rates with freestanding office rates.

Table 3. E&M office visits and cardiac imaging services are migrating from freestanding offices to OPDs, where payment rates are higher

Type of service	Share of ambulatory services performed in OPDs, 2011	Per beneficiary volume growth, 2010-2012	
		Freestanding office	OPD
E&M office visits (CPTs 99201 through 99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), OPD (outpatient department), CPT (current procedural terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of Standard Analytic Claims Files from 2010 and 2012.

The trend of hospitals purchasing physician practices is also leading to higher spending by private plans outside of Medicare and higher cost sharing for their enrollees. Many articles in the press have documented this trend, including pieces in the Wall Street Journal, New York Times, and USA Today. In one example, from an August 2012 Wall Street Journal article titled *Same Doctor Visit, Double the Cost*, a patient found that his insurance plan paid \$1,605 for an echocardiogram after his cardiologist's practice was acquired by a hospital system—more than four times the amount paid by the plan when the practice was independent. The patient, who had a high deductible health plan, had to pay \$1,000 of this larger bill. According to the patient,

“Nothing had changed, it was the same equipment, the same room.” In another example, a patient who received a 20-minute exam in a hospital-owned practice was charged a \$500 facility fee in addition to the physician’s \$250 professional fee. In some cases, private plans have stopped paying the additional facility fee for routine office visits provided in hospital-owned entities.

Reforms to eliminate price differences across sites of care

One way to address payment variations between freestanding offices and OPDs is to revise payment rates in the OPPS so that payments are equal whether a service is provided in a freestanding office or in an OPD. However, for many services, equal payment rates would fail to account for some important differences between freestanding offices and OPDs that can lead to higher costs in OPDs. First, hospitals incur costs to maintain standby capacity for handling emergencies. Medicare payments for emergency department services include these standby costs, and, therefore, hospitals should be paid more for these services. Second, for certain other services, patients treated in OPDs are sicker than patients receiving the same services in freestanding offices, and these sicker patients may require more resources. Third, the OPPS combines the cost of a primary service (such as a procedure) with ancillary services and supplies into a single payment to a greater degree than does the PFS. The PFS tends to pay separately for each component of a service. This difference in the packaging of services should be considered when comparing payment rates between settings.

Stakeholders have also argued that Medicare should pay more for all services in the OPD – not just emergency services – because hospitals incur higher overhead costs than freestanding offices. For example, hospitals must comply with more stringent building and life-safety codes. However, we believe that to be a prudent purchaser of medical care, Medicare should not pay more for a service when beneficiaries can safely obtain the same service in a lower cost setting. The Commission has consistently argued that an individual provider or sector’s higher costs is not an argument by itself for higher payments.

In order to account for legitimate differences between freestanding offices and OPDs, the Commission developed five criteria to identify services that are good candidates for setting OPD payment rates equal to freestanding office rates:

- Services are frequently performed in freestanding offices (more than 50 percent of the time). This indicates that these services are likely safe and appropriate to provide in a freestanding office. Also, the PFS payment rates for these services are sufficient to assure access to care.
- Services entail minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services).
- The services are infrequently provided with an emergency department (ED) visit when furnished in an OPD (such services are unlikely to have costs that are directly associated with operating an ED).
- Patient severity is no greater in OPDs than freestanding offices.
- The services do not have a 90-day global surgical code (CMS assumes that physicians' costs for these codes are higher when performed in a hospital than a freestanding office).

Equalizing Medicare payment rates across settings for E&M office visits

In our March 2012 *Report to the Congress*, we focused on nonemergency E&M office visits because they are similar across settings. For these services, it is reasonable to equalize payment rates in the PFS and the OPDS because:

- Hospitals do not need to maintain standby capacity for E&M visits that are not provided in an ED
- The extent to which ancillary items are packaged with E&M services is similar across the PFS and OPDS. We estimate that ancillaries only add about \$2 to the payment rate of the average E&M visit provided in an OPD.

The Commission recommended that total payment rates for an E&M visit provided in an OPD should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting.

Aligning payment rates between OPDs and physicians' offices for other types of ambulatory services

In our June 2013 and March 2014 reports to Congress, the Commission examined other ambulatory services frequently performed in freestanding offices that receive higher Medicare

payments in OPDs. We found 66 categories of services that meet the criteria above. These are candidates for having their OPD payment rates aligned with the PFS rates. We classify these services into two categories:

- Group 1 includes 24 categories of services. These meet all five criteria and OPD payments rates would be set equal to freestanding office payment rates.
- Group 2 includes 42 categories of services. These meet four of the criteria, but have greater packaging of ancillary items in the OPDS than the PFS. The OPD rate would be set higher than the freestanding office rate, but the difference should be reduced from the current level. The higher price for OPD services would reflect only the cost of ancillary items that are packaged into the unit of payment in the OPDS but are paid separately in the PFS.

The Commission recommended that differences in payment rates between OPDs and freestanding offices be reduced or eliminated for these 66 service categories.

Equalizing payment rates between OPDs and ASCs for certain ambulatory surgical procedures

We also explored a policy that would equalize payment rates between OPDs and ASCs for certain ambulatory surgical procedures. Medicare currently pays 81 percent more in OPDs than ASCs for the same procedure, and this payment gap has increased over time, influencing some ASC owners to sell their facilities to hospitals. Beneficiary cost sharing is also much greater in OPDs than ASCs. We identified 12 groups of services that are commonly performed in ASCs for which the OPD payment rates could be reduced to the ASC level. These services are infrequently provided with an ED visit when furnished in an OPD and have an average patient severity that is no greater in OPDs than in ASCs. Because the ASC payment system and the OPDS use the same rules for packaging ancillary items with the primary procedure, the unit of payment is the same in both settings.

Limiting Medicare revenue losses for hospitals that serve a large share of low-income patients

Some hospitals may serve as the primary source of access for low-income Medicare patients. Therefore, policymakers may wish to consider a stop-loss policy that would limit the loss of

Medicare revenue for these hospitals. For example, one option is to base eligibility for such a policy on a hospital's percentage of Medicare inpatient days for patients who are eligible for Supplemental Security Income (SSI). Then, Medicare revenue losses for eligible hospitals could be limited to a specified percentage, e.g. 1 or 2 percent. Finally, policymakers could choose to make the stop loss policy temporary or permanent.

Conclusion

The Commission has discussed and recommended many changes that would increase the value of Medicare's purchases and improve the coordination of care beneficiaries receive. Several of these policies could be implemented in the near-term and would serve as building blocks for broader payment reforms. In the future, the Commission envisions Medicare moving toward payment systems that are based solely on the needs of the patient, irrespective of the site of care, and that give providers greater accountability over the quality and cost of the care provided to Medicare beneficiaries.

Mr. PITTS. The Chair thanks the gentleman. I will begin the questioning, and recognize myself for 5 minutes for that purpose.

Mr. Miller, some have proposed that post-acute care bundling reforms are premature and should not even be considered by Congress until such time as a standardized assessment tool is created and data collection is complete. Others have pointed to the fact that such perfecting of data collection could take a decade or more, and even then, such an assessment will need to be refined. Do you agree with the notion that Congressional consideration of bundling should only occur after an assessment tool has been created and sufficient data collected, or can both be done concurrently?

Mr. MILLER. OK. I think the Commission's view on this works as follows. I think there is a very strong consensus and a recommendation that we need a common assessment instrument. We think that that is a lynchpin to improving both our measurement and payment and organization and coordination over the long haul. So there is no question that should happen. We have made recommendations. We have given a timeline. We have talked about an instrument. And just for the record, we have been pushing for this for over a decade, so I have got to make sure that I say that.

On bundling, I think the Commission believes that bundling is a viable option and is one that should be pursued, but there is a large set of technical issues that the Commission went back and forth on, and I can take you through some of that but we will see where you want to go here, and I think their view is that there should be experimentation, which is occurring now, and to see which of the models tend to jell and work best for both the beneficiary and the program. So I guess what I am saying to you is, we should be pursuing both.

Mr. PITTS. All right. Medicare payments are a huge influence on the health care industry, often serving as a baseline for negotiations between hospitals and private insurance. Do private payers mimic Medicare site-of-service reimbursement disparities?

Mr. MILLER. OK. A couple things here. It is correct that you find the same phenomenon in the private sector as you find in Medicare where if you pay for a similar, or if you see a similar system or service in the hospital setting, it is usually paid higher by private insurance. I think there is more than—there is more to that than just the notion that Medicare does it, so too does the private sector.

Over the last several years, the private sector and hospital systems have become much more consolidated and they are able to extract higher prices in their negotiations with insurers, and that certainly contributes to the higher prices that you see in the hospital setting versus other settings. So I don't think it is just simply mimicking Medicare but the same phenomenon is observed in the private sector.

Mr. PITTS. Do private insurers obtain similar discounts for care that is provided through physician offices and ambulatory surgery centers?

Mr. MILLER. I am just going to use a slightly different word. I think what you will see in the private sector is that the payment rates in ambulatory centers and physician offices tend to be lower than the hospital. Whether those are extracted discounts is just sort of a terminology point. I think it is true that they have lower

rates in ambulatory surgery centers and the physician's office for the same service relative to the hospital.

Mr. PITTS. Have any private insurers adopted site-neutral payment policies similar to the recommendations that MedPAC has made to Congress?

Mr. MILLER. I don't have data, and, you know, really rigorous information on this point. What I can point you to, and I have certainly talked to the committee staffs about this, there is widespread newspaper reports where privately insured folks are showing up at the physician's office after a physician has transferred to a hospital ownership and seeing their cost-sharing go up, you know, significantly, and this has been reported on a widespread basis, and what we have heard in discussion, but there is not a lot of science behind this, is there have been some private insurers have refused to pay the additional facility fee for regular office visits in the hospital setting. So I don't want to overplay that but that is more anecdotal and what we are reading and hearing in discussion.

Mr. PITTS. The respected journal, Health Affairs, this week released a study finding that hospital ownership of physician practices is associated with higher prices and spending. Can you comment on how Medicare's payment differentials might have spillover effects to the private sector and health system?

Mr. MILLER. Again there, I think part of what is going on, and I did look at that when it came along but I am sure I can dredge it right back up, but I think part of the explanation there is some of the consolidation and the ability of hospital systems on the private side to extract higher prices. I think what you are seeing both in the private and in the Medicare payments is this ability to arbitrage, to say if I can move a practice into the billing stream for the hospital side, both for private insurance and for Medicare, the hospital will get more revenue. So that certainly seems to be going on, and what we are concerned about is, while it is not the only reason that a hospital would purchase a physician practice, because there are other motivations for doing that, the fact that Medicare's payments are so much higher on the hospital side certainly encourages the migration, and we are seeing a fair amount of it.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Miller, I am amazed by how much variation exists in the care provided in the post-acute setting. There is no uniform assessment of where a patient should go following a hospital stay. Does a patient with a hip replacement fare better in a skilled nursing facility or home health agency? We don't really know. And how much post-acute care does a typical hip replacement patient need? We don't really know. So given that the Medicare program spent \$62 billion on post-acute care in 2012, I am amazed we don't have better information about patient outcomes, service use or quality of care.

So my question is, does MedPAC view this as a problem, and what do we do about that and how can we quickly move to a place where we have info to know what kind of care is being provided?

Mr. MILLER. OK. You are right. There is significant geographic variation, or significant variation, not even just geographic, even with the same marketplace and the amount of post-acute care. I think there is a couple issues there, the one that you referred to, which I will come right back, and the notion that it is hard to define in many instances, you know, the amount of post-acute care that a patient should get, when do you stop rehab, you know, for some—

Mr. PALLONE. I agree.

Mr. MILLER [continuing]. And where—

Mr. PALLONE. I am going to answer the question myself.

Mr. MILLER. So the Commission, as I said, a little bit in my opening comments, many years ago said we need a common assessment instrument. It took a long time, but the Congress then called on CMS to develop an instrument and to test it, which they did through the care demonstration, and that instrument now exists. We believe, and we have made a recommendation along these lines, you can take the elements from that instrument—doesn't have to be the whole, giant thing—put them into each of the current collection instruments that exist for SNF, home health, require one for long-term-care hospitals and then you will be able to sweep up that information across the settings and be able to start making judgments about does a patient have a better outcome in one setting versus another, what is the average resources, the very things you are saying, for hip replacement as the case may be. We laid out a 3-year process to get that information integrated into the collection instruments and then have a product. So yes, that is what we should be doing.

Mr. PALLONE. And, you know, I do think that is important to have but, I mean, it is always going to be individual case too, though, obviously.

There have been a number of proposals to bundle payments for post-acute care, and the President's budget proposed to bundle 50 percent of PAC spending by 2019. Mr. McKinley is working on a bill that would bundle payments for care and pay a reduced rate. But how can we develop a bundled payment rate or develop the items that go into a bundle or develop appropriate risk adjustment? I mean, it is obvious if we don't have basic data, that is going to be difficult, so that is obviously why you think the data is important.

Mr. MILLER. And in some ways, this is this question that came up, is it an either-other type of thing, and I think the urgency in some of what you have laid out at the beginning really requires that we proceed on both tracks. So let us just say that there is a bundle—there is a lot of complexity in assembling a bundle but just for half a second let us pretend that we have some sense of what that is. One way that you can kind of mitigate against the fact that you don't have ideal information is, you could continue to use a fee-for-service model underneath a set platform, so you don't have a stinting incentive. In order to get paid, the person has to provide the services. You put a small portion of the payment, let us just for discussion call it 5 percent, and then you do have measures, and the Commission had worked with these and there are others out there on things like avoiding the emergency room, avoiding the

hospital and community discharge and say OK, those are the three outcomes we are looking for, here is the block of dollars and then get providers who are willing to take that risk and manage the patient through that episode, and that is imperfect information but we are assuming that the provider will have tools to have more accurate information on the ground while the program is developing through this unified assessment instrument.

Mr. PALLONE. I know we are almost out of time, but could you just quickly—

Mr. MILLER. Sorry about that.

Mr. PALLONE [continuing]. Talk about the stinting or potential dangers in the bundled payment or capitated payment design?

Mr. MILLER. It is always an issue when you—I mean, you know, fee-for-service has the issues that I have raised, fragmentation and generation of volume. Any time you go to an episode, capitated, you know, whatever the case may be, you have the reverse problem where you create the incentive to under-provide. You have to either have a mechanism that encourages that like paying on a service basis underneath a cap or you have to have quality—and you have to have quality measures that say to the provider, you are not going to get paid or not get your withhold back or whatever the case may be unless these quality metrics are met. But it is decidedly an issue. It is not something to be brushed past.

Mr. PALLONE. All right. Thanks a lot.

Thanks, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and Mr. Miller, thank you for being here this morning.

In the report from June of 2013, you discussed the increase hospital consolidation, particularly in the cardiology space. Has MedPAC seen this trend in other specialties?

Mr. MILLER. I am not sure I can break it down for you by specialty, but yes, we have seen it in other services, not just simply cardiology services. But yes, we have seen it in other services.

Mr. BURGESS. And those other services, examples of those would be?

Mr. MILLER. You know, certainly the E&M, you know, basic evaluation and management visits are shifting. I guess some of the ones that immediately come to mind are cardiology, echocardiograms. There are probably some other examples I can't dredge up at the moment.

Mr. BURGESS. What about clinical oncology?

Mr. MILLER. OK. So in that, you know, obviously understanding that there was going to be a hearing, we looked at it a little bit, and just before I answer, yes, there are a few oncology—when we went through our recommendations that were in the March 2014 report, and we have the set of services that we are saying should be set to the physician fee schedule rate, there are a few services in there, two, three services, that seem to be related to oncology but we didn't approach it as a specialty or a service line approach. We had a set of criteria and said if services meet this criteria—I won't drag you through it unless you want to hear it—then the

service was put into the policy, but we didn't approach it as oncology, cardiology.

Mr. BURGESS. Could you perhaps that in writing? I will ask the question for a written response.

Mr. MILLER. Yes.

Mr. BURGESS. I actually would be interested in the thought process in going through that, but we don't need to go into that now.

Have you looked at what happens to patient access and costs with hospital acquisitions around different specialties?

Mr. MILLER. Well, what we look at every year, both in the hospital setting and in the physician setting and in every other setting that we look at, we look at access and utilization. Now, if your point is—and it may be—well, what happens to access if we get this migration into the hospital for oncology services, we haven't looked at that recently. We looked at it several years ago. We haven't looked at that specific phenomenon. But we broadly look at access year and report to the Congress.

Mr. BURGESS. When you say several years ago, like how many years ago?

Mr. MILLER. Longer than I would report the results.

Mr. BURGESS. So—

Mr. MILLER. Eight.

Mr. BURGESS. So prior to the passage of the Affordable Care Act?

Mr. MILLER. One more time?

Mr. BURGESS. Prior to the passage of the Affordable Care Act?

Mr. MILLER. Yes.

Mr. BURGESS. So have done any kind of estimate on the return on investment to this trend? What are the costs/benefits as far as patients and their access to care, the cost-benefit analysis for this consolidation?

Mr. MILLER. So the migration from the physicians' offices to the hospital?

Mr. BURGESS. Correct.

Mr. MILLER. At least for the services that we looked at and met our criteria, which I realize we haven't had that conversation, for about 66 of them that met our criteria, and if you look at that, it is about a billion dollars of program spend and about let us call it \$200 million in beneficiary out-of-pocket that is being incurred because these are being migrated. We have not seen access issues but again, we haven't gone in by service line or specialty to see that, but we have not seen access issues.

Mr. BURGESS. But there is a dollar impact?

Mr. MILLER. Oh, yes, and I tried to point that out in my 5 minutes.

Mr. BURGESS. And one of the reasons I am concerned about this, and I don't have the article in front of me but I think it was in August of 2011 in the Annals of Internal Medicine, if I recall correctly, Ezekiel Emmanuel wrote an article about the fact that doctors really shouldn't fight the concept of being employed by an entity, presumably a hospital or insurance company or even a governmental entity, that this would be a better way to deliver care. It frees the doctors from having to worry about the vagaries of running a business, but because of the Affordable Care Act, there is this pressure for consolidation, and I ask myself all the time, just

from a professional standpoint, is this a good thing or a bad thing. I come from a long line of a medical family, and our contract was always with the patient. Our advocacy was always supposed to be for the patient. If I work for the hospital, then suddenly that dynamic changes and I am not certain—and I can't put a dollars-and-cents figure on that. I don't sense that that necessarily is an improvement in the practice of medicine. Obviously, a philosophical article but I am concerned about the effect of consolidation cost being used as a driver.

I have got several other questions I would like to ask you, and I will submit those in writing, and the chairman will delineate how we get those responses.

Mr. MILLER. I see 37 seconds, so—

Mr. BURGESS. That means I am over, but proceed. That is a surrogate endpoint.

Mr. MILLER. OK. I mean, one thing I would say is, I don't think the Commission is—I am sure the Commission is not making a statement about better or worse ways to organize practice. What the Commission is saying is, it shouldn't be driven by distorted prices. Those decisions should be made by a physician saying I want to practice this way or I want to practice that way or what the best episode and arrangement is for the beneficiary, and it shouldn't be just this price-driven phenomenon.

Mr. BURGESS. And I agree with you completely.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I want to talk to you about observation status and then what it means for post-acute care. This has been a huge issue for constituents in my district who when they get to the hospital and they are put into a room think I am admitted to the hospital, and my understanding is that it is open-ended how long observation status can actually occur, and then if they end up going to a skilled nursing facility, then they find out that Medicare doesn't pay anything. They thought they were admitted to the hospital, for good reason. We find frail, elderly people sometimes with certain mental deficiencies, and if they are in the hospital and they are in the hospital a few days to assume that they are admitted to the hospital seems logical.

So we have had large numbers and dealt with CMS a lot on this question of observation status. So I wonder if you could just clarify this for me and how it impacts then the post-acute care status in terms of payment?

Mr. MILLER. OK. I am not as deep for this hearing as maybe on some other things.

So I think the issue that you are getting at—you tell me to redirect if we are not on the same wavelength—is that if somebody enters the hospital and ends up, let us just say for the sake of discussion, in three days of observation care, although lots of observation stays last much less than that, then while they by all appearances to the beneficiary and their family, they have been in the hospital,

they won't have qualified for the 3 days of hospitalization needed to qualify for skilled nursing care.

Ms. SCHAKOWSKY. That is correct.

Mr. MILLER. I think that is the point that you are driving at.

Ms. SCHAKOWSKY. That is correct.

Mr. MILLER. And I think, you know, the dilemma for the Congress is that, you know, when a beneficiary feels, and for almost all intents and purposes has been in the hospital, the concern is that they should qualify. Of course, the issue that has to be dealt with—and then I am going to get you to a happier place in just a second—the issue that has to be dealt with is, if you simply remove that 3-day requirement, the estimators, the Congressional Budget Office and folks like that, believe that the skilled nursing facilities will start to get community admits and then the costs will go up significantly. So there is an issue that gets kind of enjoined there.

But the happier place perhaps—

Ms. SCHAKOWSKY. I don't understand what you just said, that they will get community admissions.

Mr. MILLER. So if you say to—if you were today—and this is something you should check—this is what I understand, and I am a little bit off base, but this is what I understand. If you said today there is no 3-day requirement to stay in the hospital to go into—

Ms. SCHAKOWSKY. No, no, I am not saying that.

Mr. MILLER. Well, I am just saying if you did, you would run into a cost.

Ms. SCHAKOWSKY. Yes, OK.

Mr. MILLER. So there are other avenues to potentially explore here. One is—and the two discussions that—and I have some work going in the background although I haven't brought it forward yet because it is not far enough along, is looking at the inpatient hospital payment system and creating a short-stay payment so that they don't have to have this choice between observation care and short-stay inpatient stay, and then the person would come in in the inpatient and it would be classified as an inpatient stay. So there is both an observation versus inpatient issue there and it has bearing on your skilled nursing facility question.

Ms. SCHAKOWSKY. Correct.

Mr. MILLER. We are not far enough to have a nice, concrete conversation about the specifics but we are working on that.

Ms. SCHAKOWSKY. OK. I think it is really important. I can't tell you how many elderly individuals and couples have just been astonished at being—they are not really admitted to the hospital. It just doesn't make sense.

Mr. MILLER. I hope you are hearing that we are taking this seriously because nothing I have said should have given you anything other than that.

Ms. SCHAKOWSKY. And is there any timeline built into this?

Mr. MILLER. You know, we are working with data, we are talking to hospitals. These are kind of messy issues. There is a RAC auditor issue kind of mixed in there as well. We are working on it, is the best I can tell you at this point.

Ms. SCHAKOWSKY. Let me just submit for the record, there is a question I want submitted that deals with post-acute providers' high profit margins that I want to get to you as well. Thank you.

Mr. MILLER. I would be happy to talk about that.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman, Mr. Rogers, 5 minutes for questions.

Mr. ROGERS. Thank you very much.

Thank you, Director, for being here. Over the last 5 years, 47 community practices have started referring all of their patients elsewhere for treatment. Two hundred and forty-one oncology office locations have closed and 392 oncology groups have entered into an employment or professional services agreement with a hospital. That is a fairly staggering shift in 5 years. What would you attribute that significant shift toward a hospital setting?

Mr. MILLER. You know, with respect to oncology, I am a little bit of a deficit here to give you the specifics related to that. The broader trend that we are seeing we think are the trends that I have been speaking to up to this point. There is a lot of consolidation out there. I think the hospital's motivations come in a couple of varieties. There is this notion of building systems and coordinating care, which may be a good motivation. There is capturing referrals, and, to the extent to that the Medicare and the private sector pays more when you make that jump, then there is that motivation.

On the physician side, and this goes to some of what Mr. Burgess is saying, I hear both kinds of conversations, ones that are "I am very upset by this trend and I don't want it to happen," and other physicians who say this actually frees me up to kind of focus on care, and I am not saying that is the oncology argument but I have heard that from other practices. I think this is kind of a complex set of currents running in both directions.

Mr. ROGERS. Although in a market economy, if the hospitals pay more for exactly the same services, it is pretty hard to argue that that isn't a significant factor.

Mr. MILLER. And you do hear us saying that is what we—

Mr. ROGERS. I just wanted to clarify that number because I was staggered by it. A \$1 billion increase, if I heard you correctly, from that migration to the hospital setting of which \$200 million is borne by the hospital—or excuse me—by the patient. Did I understand that correctly?

Mr. MILLER. Yes, and just to clarify, for the 66 services that we have identified which may or may not encumber the ones that you are referring to, we think on an annual basis we are talking about a billion dollars, and just for round numbers, let us say the beneficiary carrying 200.

Mr. ROGERS. That is a significant cost increase for the patient, is it not?

Mr. MILLER. Yes, and—

Mr. ROGERS. It is a 20 percent increase.

Mr. MILLER. Yes. There are examples of these differences. For example, for cataract surgery, if you get it in a physician's office, the copayment is \$195. If you go into the hospital, it is \$490. That is the beneficiary's—

Mr. ROGERS. And 20 percent of that increase, according to your numbers, would be borne by the patient?

Mr. MILLER. No, that is the beneficiary's increase.

Mr. ROGERS. That is just the beneficiary's increase?

Mr. MILLER. The program increase goes from about \$1,000 to about \$1,800 on the program side.

Mr. ROGERS. That is a significant out-of-pocket increase for those patients, is it not? So if you look at something like—let us talk about some kind of radiation treatment, somewhere between 6 and 8 weeks. So we have had this major displacement of at least places that are convenient for treatment, a daily transportation for the 6 to 8 weeks for these treatments and a roughly 20 percent increase. Someone has to tell me why that is good for the patient.

Mr. MILLER. Again, I can't speak to your very specific oncology examples. Our concern is motivated both by the program dollar and beneficiaries out-of-pocket.

Mr. ROGERS. And I would hope that you would consider travel times. When you are getting radiation treatment, obviously I am specific to oncology here, but you are already tested to the limit, and increased commute times and pay more money doesn't seem like a good idea for care to me.

I mean, have you done anything that shows a benefit to the patient from moving to hospitals? Is there any white paper I can look at? Is there anything that tells me that this is a good idea for people like cancer patients, or in your case, cataract patients?

Mr. MILLER. I want to answer this carefully. We have not done anything, which doesn't mean it doesn't exist. It is just that we haven't done anything. So I am unable to point you to something but it is not because I know that is the answer. It is just because we haven't done anything.

Mr. ROGERS. I thank you, and my time is running out, but Mr. Chairman, thanks for having this hearing. I think just the fact that we pointed out the significant cost to patients, number one, not only in just dollars but the anxiety that comes with getting in that car and driving a greater distance just to have access to care means that we ought to do something about this yesterday. We already have lost 392 plus the 241 just oncology, just oncology centers are gone, and wrapped up in this system. Two hundred and forty-one just closed completely. The longer this goes, the more we will lose, the more patients that will be impacted by out-of-pocket costs, and again, all of the anxiety and trouble that is caused by greater distances is very, very troubling.

I appreciate you having this hearing. I think this has highlighted a very important issue that needs immediate attention. I yield back my time.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Murphy from Pennsylvania 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman. I want to follow up on some of the issues presented by my friend Mr. Rogers of Michigan.

So when we are looking at the out-of-pocket costs a Medicare patient may pay, they will pay a copay for some chemotherapy and other treatments, and is that a percentage basis or is it a flat dollar?

Mr. MILLER. It is usually 20 percent just because nothing is simple. It varies a bit in the outpatient department on a percentage

basis due to some very old historical issues that are being changed over time. But for purposes of conversation, think 20 percent.

Mr. MURPHY. OK. And rather than look at the aggregate amounts totally, so if somebody was getting some treatment at a clinic—well, those clinics that haven't closed yet—versus at a hospital, any sense of what the comparative price would be for individual treatments in one place for another?

Mr. MILLER. For a clinic?

Mr. MURPHY. A clinic or a physician's office or a hospital. You know, we are talking about the differences in disparity here.

Mr. MILLER. If I understand your question, some of the data that we have put out suggests that evaluation and management issue or a visit is paid about 80 percent more in the hospital setting. An echocardiogram is paid about 130 percent more in the hospital setting.

Mr. MURPHY. So if they are paying 130 percent more in the hospital setting, that means the patient is paying more in the hospital setting too if they are paying 20 percent, but do you have any idea what that dollar value might be. I know it probably varies by region.

Mr. MILLER. Well, you know, there is some adjustment for wage index and things like that but I think this is correct if you don't—I have some scribbled notes that I was writing down last night. I think, for example, on the echocardiogram, the beneficiary's copayment goes from about \$40 to \$90. The program payment goes from about \$150 to \$360.

Mr. MURPHY. Which is pretty significant, especially if someone is on fixed income.

Mr. MILLER. I am sorry?

Mr. MURPHY. If someone is on a fixed income, well, under any circumstances, and of course, if a person is chronically ill and receiving a lot of medical care, that can amount to thousands of dollars in a year.

And so let me ask you another issue too. Now, some centers have a 340B program and so they are able to obtain drugs as long as, I understand, if they are a nonprofit patient they can qualify to purchase drugs on a 340B program. Am I correct?

Mr. MILLER. There may be some more requirements than that but I will stay with you for the moment.

Mr. MURPHY. Well, let us say a private physician's office or a for-profit clinic or something would not be able to purchase drugs on those discounts. Am I correct?

Mr. MILLER. I am pretty sure that is correct.

Mr. MURPHY. One of the concerns that I frequently hear about the 340B program, first of all, it is a great program. I support it strongly in many instances. But we also hear that some are claiming that there are some abuses of that program where some centers will purchase drugs at discount but then they will sell them at the markup again and get this money. Now, is that something that some of these other private clinics or physicians' offices, are they able to purchase drugs from the 340B program?

Mr. MILLER. Again, I am not deep on this, given the subject of the hearing. I didn't study down on this one. But my sense is no, that is not available to them.

Mr. MURPHY. So this adds another issue here. I mean, what I hear frequently across the board, hospitals and physicians saying that the reimbursement rates for mc doesn't really cover their costs sufficiently. They complain about the low reimbursement rates. But what you are telling me is that if we focus also on—if some of them also are making money on the 340B program, and maybe this is out of your wheelhouse, but that is another area of disparity if there are differences between people who generally qualify versus those who may not qualify but the hospital is still getting some 340B money out of this.

Mr. MILLER. To the extent that the fact set that you and I are talking about here without me doing the homework on it, yes, that would be true, and I would say to you similar to what I said to the Congresswoman over here, this is an issue that we have not come forward on because there is still a fair amount of staff work to be done, but we have started to try and look at it.

Mr. MURPHY. We hope that is information you will provide this committee.

Let me ask one last thing then. So we have heard concerns before of people with non-insurance or Medicaid versus private insurance. The survival rates are very different for people with cancer. But that is also according to the Cancer Medicine Journal, it is due to a complex set of demographic and clinical factors of which insurance status I just a part.

But let me look at this in terms of Medicare in terms of where a person actually gets their care, a hospital base versus a physician's office. Are there differences there in survival rates that you are aware of?

Mr. MILLER. I have not looked at that, which doesn't mean—I don't know the answer to that question.

Mr. MURPHY. That would be something that would be valuable for us to get to.

I thank you very much, and I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, and I would like to ask unanimous consent to place in the record a written statement by Dr. Bruce Ganz, Chair of the American Medical Rehabilitation Providers Association, regarding the post-acute care reforms being discussed today.

Mr. PITTS. Without objection, so ordered.

[The information follows:]



Bruce M. Gans, MD
 Chair, AMRPA Board of Directors
 Executive Vice President and Chief Medical Officer,
 Kessler Institute for Rehabilitation
 National Medical Director for Rehabilitation, Select Medical

**House Committee on Energy and Commerce
 Subcommittee on Health**

Keeping the Promise: Site of Service Medicare Payment Reforms

**Written Statement for the Record
 Bruce M. Gans, M.D., Chair
 American Medical Rehabilitation Providers Association**

May 21, 2014

The American Medical Rehabilitation Providers Association (AMRPA) thanks the Committee on Energy and Commerce Subcommittee on Health for the opportunity to submit comments for the hearing record. Moreover, we appreciate the Subcommittee's thoughtful oversight of Medicare payment policy and examination of ways to improve the Medicare program for seniors and all taxpayers. AMRPA shares the Subcommittee's interest in addressing variation in spending, quality and margins across different sites of service. We believe that evidence-based, patient-centric changes to the delivery system and payment policies are necessary to modernize the Medicare program and ensure that patients have access to necessary and appropriate post-acute care. Forward-thinking reforms should seek to align payment with desired changes in the delivery of care and move from a provider-centric to a patient-centric payment system. We caution, however, that effective reforms must create efficiencies and drive innovation and quality care to advance the interests of beneficiaries, rather than simply cutting payments by shifting patients to seemingly less costly (in the short run) care settings. We are also cognizant of the need to analyze downstream consequences of admission and care decisions since many important markers of quality and health outcomes may not be evident within short-term episodes of care.

AMRPA is the national trade association representing inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation centers, and other medical rehabilitation providers. AMRPA members provide medical rehabilitation services in a vast array of health care settings, including IRH/Us, hospital outpatient departments, and settings that are independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and outpatient practices in skilled nursing facilities (SNFs). While there are a number of provider types discussed in the context of post-acute care, medical rehabilitation hospitals and units are separate and distinct both in terms of quality outcomes and regulatory requirements. There is a unique population of patients who require intensive, hospital-level rehabilitative care that cannot be provided in any other setting in order to maximize their health, functional skills, and independence so they are able to return to home, work, or an active retirement.

General Principles for Post-Acute Care Reform

In order to advance post-acute care reform, AMRPA developed a set of principles for reform that will help ensure that a reformed payment and delivery system is feasible for providers and beneficial for patients. Specifically, we urge Congress to be guided by the following principles in any reforms to the post-acute care sector:

- While reforming post-acute care, Congress should take steps to reduce the need for post-acute care in the first instance. As a nation, we have a vast amount of knowledge in treating the predominant reasons that patients need post-acute care, including stroke, traumatic brain injury, spinal cord injury, congestive heart failure, chronic obstructive pulmonary disease, and serious wounds. At the same time, we know of ways to prevent them or mitigate their effects. For example, thrombolytic drugs can greatly mitigate the adverse effects of stroke if administered in a timely manner. Many brain injuries can also be prevented with appropriate protection of the head during sporting activities. Additionally, lifestyle changes such as diet, exercise, and smoking cessation also prevent the chronic conditions being seen and treated by IRH/Us. Congress should establish policies that prevent the need for acute and post-acute care as a fundamental step to reducing costs and improving outcomes.
- Qualified clinicians should determine patient care—both with respect to the type and site of care. Clinicians should be empowered to make post-acute care utilization decisions with reasonable criteria that are evidence- and consensus-based. Periodic audits could be utilized to hold physicians accountable to exercising that authority.
- Post-acute care reform should include an accurate definition of post-acute care. The current definition excludes outpatient services and is being driven by how Medicare Parts A and B are defined, not by how care is actually delivered. Post-acute care reform and reinvention will only be ultimately successful by eliminating this arbitrary divide.
- A reformed system should ensure electronic interoperability between and among different providers of care. Post-acute care providers are at the crossroads of information flowing out of the acute care hospitals, yet post-acute care providers were not included in recent health information technology (HIT) incentive programs. The absence of such funding for post-acute care providers has arguably made information sharing worse than before the incentives were provided. Post-acute care providers should be included in HIT incentives to enhance patient care safety and efficiency, and reduce costs.
- A reformed system should create a mechanism to promote frank and open discussion between acute care hospitals and post-acute care providers to identify and rectify adverse health outcomes that occur because of care transitions.
- The current post-acute care system, including provider fee schedules and coverage criteria, is long-standing. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a reformed system should include a sufficient transition period and resources for such education. All stakeholders, including health care professionals and patients, should be consulted in the development of a new Medicare physician payment system.
- A reformed system should include a quality measurement and reporting system for post-acute care

providers that should be based on the principles of:

- Avoiding adverse events;
 - Achieving positive health outcomes;
 - Achieving positive functional gains;
 - Providing a positive patient experience;
 - Achieving durable health and functional gains; and
 - Demonstrating efficient and cost effective use of resources.
- Payments must reflect the true cost of care and resources utilized based on the patient's conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionately penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.
 - Provider administrative burden should be minimized whenever possible. Current regulations that inhibit the use of the most cost effective setting—such as the 3 hour rule for IRH/Us and the 25 Percent Rule for L.TCHs—should be eliminated and replaced with incentives to use post-acute care settings prudently.
 - The payment eligibility criteria for post-acute care providers should be reformed based on structure, process, and outcomes for each setting, and these criteria should not be confused with defining appropriateness for a specific patient.

IMPACT Act

Recently unveiled draft legislation by the bipartisan, bicameral staff of the Senate Finance and House Ways and Means Committees reflects the understanding that payment changes cannot be meaningfully implemented without comparative data of the quality and outcomes across different sites and settings of care. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 takes a measured approach of analyzing and reporting to Congress on payment system reform.

While AMRPA has various concerns with the scope, timeline, and details of the draft IMPACT Act, the bill's general approach has merit in first identifying the building blocks of reform. Specifically, the legislation seeks to use performance assessment as a foundation for changes to the payment system. It also recognizes that standardized data and common data tools are a requisite foundation for accurate resource use and other quality comparisons. In sum, the IMPACT Act recognizes that data systems must be overhauled before quality can be accurately assessed across care settings and thus payment and service delivery policy can be improved. AMRPA believes this systematic approach represents an affirmation that moving hastily to institute payment reforms like bundling or "site neutrality" in the absence of a complete understanding of the differences between sites of care would be detrimental to patients and the Medicare program in general.

BACPAC Act

Representative David McKinley's Bundling and Coordinating Post-Acute Care ("BACPAC") Act of 2014 (H.R.4673) recognizes important limitations in the current payment system, but attempts to superimpose a complex new payment model on a tenuous foundation. Although AMRPA believes that the health care system should explore ways to transition toward patient-centric, episode-based models of care, doing so should not create financial disincentives for patients to receive medically appropriate inpatient rehabilitation care.

Current Medicare payment policies are defined by “silos” of post-acute services and have substantial room for improvement with regard to efficiency and patient-centricity. AMRPA could only support a well-developed bundling proposal that is built upon an adequate foundation of data integration and based on sound evidence with fully developed quality measures and risk-adjusted payment systems. At this time, a bundled payment system that includes critical beneficiary protections does not exist and it would likely take several years to develop, adequately test, and validate.

Absent sufficient safeguards for patient access and choice, AMRPA is not able to support legislating broad bundling reforms that lock-in federal savings and defer to the Secretary of HHS to implement a skeletal bundling plan for the post-acute care sector. The potential savings to the Medicare program from prematurely implementing a bundling payment system on the current foundation are dubious and far outweighed by the unjustifiable risk to Medicare beneficiaries.

At this time, AMRPA cannot support the BACPAC Act of 2014, as drafted. At a minimum, we propose the following important revisions:

- **Bundle Coordinator**: AMRPA supports the BACPAC’s designation of a physician as the individual charged with making treatment decisions under the bundle, as well as the requirement that this physician have experience in post-acute care/rehabilitation service delivery, including the implementation of post-acute care plans.
- **Holder of the Bundle**: AMRPA opposes the proposal to permit acute care hospitals and insurance companies to serve as the “holder” of the bundled payment for the 90-day bundling period. Regardless of their ability to bear risk, this approach imposes formidable disincentives to divert patients to the least costly setting, regardless of patients’ specific clinical needs. Regardless of the structure, the bundle holder should be accountable for performance across a series of quality and outcome measures to protect against underservice.
- **Risk-Bearing Entities**: The holder of the bundle must be able to fully assume the risk of holding this bundled payment while providing services to a beneficiary over a 90-day episode of care. The legislation should require financial solvency and related standards to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. These standards should be specifically adapted to the post-acute care setting.
- **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: Bundling is a concept that has not been sufficiently tested and, while AMRPA does not oppose the concept, we strongly believe that adequate safeguards must be included in any legislation to protect vulnerable Medicare beneficiaries. Among these beneficiaries are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they constitute particularly vulnerable subgroups that ought to be exempt from the initial phases of any bundled payment system, until new payment systems can demonstrate sufficient quality outcomes, risk adjustment, and patient safeguards to ensure quality care.
- **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle**: AMRPA believes that certain devices and related services should be exempt from the bundled payment system. For example, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period,

as well as prosthetic limbs and orthotic braces, custom mobility devices and Speech Generating Devices (“SGDs”). Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay has potentially significant negative consequences for patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

- **Inclusion of Quality and Outcome Measures:** Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care. This is one of the most critically important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTCH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But the reality is they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care. Therefore, AMRPA recommends that the following measures be incorporated into the PAC system:
 - **Access and Choice:** Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice;
 - **Function:** Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
 - **Individual Performance:** Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the “average” patient;
 - **Quality of Life:** Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);¹ and
 - **Patient Satisfaction:** Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.²
- **Avoid Financial Incentives to Divert Patients to Less Intensive Settings:** In order to protect against diversion of patients to less intensive, inappropriate PAC settings, we recommend that any PAC bundling legislation include instructions to the Secretary that payment penalties should be established to dissuade PAC bundle-holders from underserving patients or stinting on care.

¹ These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ (“AM-PAC”™).

² “uSPEQ” (pronounced “You Speak”) is an example of a patient satisfaction assessment tool that measures the end users experience with their post-acute care experience. The survey can be answered by the patient, family or caregiver.

AMRPA reiterates its concurrence with proponents of the IMPACT Act that introducing bundled payments in the absence of a complete quality picture, infrastructure to seamlessly coordinate services, and data that transcends individual sites of care would be premature.

Site-Neutral Payments

Although AMRPA supports consideration of payment reforms that focus on the individual patient rather than the provider or setting, leading proposals to establish “site neutral” payment rates cause far more problems than they resolve. Current proposals to equalize payments to IRH/Us and SNFs for certain conditions create financial barriers to inpatient medical rehabilitation and shifts patients to nursing homes based on their diagnoses alone, without taking into account their individual medical and functional needs. Admission decisions and treatment plans should not be based on punitive Medicare policies, but should instead center on the clinical needs of individual patients.

The concept of neutral payment presupposes that the care rendered in different settings is equivalent and thus the payment should be neutral. Not only is that premise unsubstantiated by evidence, but the regulatory framework implies the exact opposite. There are strict coverage criteria for inpatient medical rehabilitation, and IRH/Us are subject to extensive medical requirements that do not apply to other providers. The coverage criteria for IRH/Us are highly unique within post-acute care, incredibly rigorous, and include extensive documentation requirements. IRH/Us must have medical directors and nurses who specialize in rehabilitation, have 60 percent of admissions come from thirteen specific categories, and can only admit patients who require, and can tolerate, three hours of interdisciplinary therapy a day, as well as the potential to meet predetermined goals.

These criteria demonstrate the central role that rehabilitation physicians fulfill in preadmission screening, admitting the patient to the hospital, conducting a post-admission evaluation in addition to the patient history and physical examination, developing the individualized overall plan of care, leading weekly team meetings and seeing the patient for at least three face-to-face visits per week to assess and adjust the rehabilitation program. This type of intensive medical care is not appropriate for many patients and thus these requirements are not imposed for other sites of care. However, Congress should not impose site neutral payment rates without concurrently establishing site neutral regulatory standards.

CMS presently lacks the requisite data to compare the care delivered across different settings. The leading indicators, however, reveal that the care delivered in different settings is far from comparable. IRH/Us achieve superior results in a shorter amount of time compared to other sites of care. For more than a decade, Medicare patients have consistently had an average length of stay of approximately 13 days in IRH/Us compared to more than a month in even relatively efficient nursing homes. More than 80 percent of IRH/U patients achieve discharge to home after rehabilitation, compared to approximately 45 percent of SNF patients. Also, acute hospital readmission rates for SNFs far exceed rates for IRH/Us. According to MedPAC’s March 2013 Report to Congress, 19.2 percent of SNF patients were discharged to acute care and 28 percent were rehospitalized directly or within 30 days, compared to 10.3 percent of rehabilitation inpatients with 12 percent readmitted within 30 days. These aggregate figures mask that for certain conditions, such as hip replacement, the disparity in unplanned readmission and length of stay is far more extreme.

Unfortunately, CMS has never comprehensively analyzed the comparative costs of medical rehabilitation and nursing home care over an entire episode of care. Taking into account discharge to home and community and readmission costs, the reality is that medical rehabilitative care is not significantly more costly than nursing home care and may be the less costly alternative for many Medicare beneficiaries.

According to a recent longitudinal analysis by Dobson DaVanzo & Associates, patients treated in IRFs had significantly better long-term clinical outcomes than those treated in SNFs. Specifically, IRFs patients returned home from their initial stay two weeks earlier, remained home nearly two months longer, and survived nearly two months longer than clinically-comparable SNF patients.³ Congress should consider the true cost differentials and quality outcomes across an entire episode of care before enacting reforms that seek to shift patients from one care setting to another.

Without a systematic way to account for these vast disparities, AMRPA worries that site neutral payments represent a redistributive proposal under which beneficiaries will be deprived of access to medically necessary care while other providers will gain market share at the expense of clinically appropriate, hospital-level, quality care. Moreover, due to the hidden costs associated with rehabilitation in other post-acute settings, actual savings to the Medicare program will never be realized.

Bundled Payments

Through thoughtful and transparent deliberation, AMRPA believes that an approach to bundling payment could be developed that has the potential to meet the twin aims of improving quality and reducing cost. Bundling typically involves payment to one accountable entity for a predefined grouping of items and services, which may be supplied by various providers and settings, for an episode of care. It is imperative to test bundling different components of post-acute services together before moving to bundle acute care services with post-acute care services. Moreover, it is critical that any bundled payment program include incentives to provide high-quality care in the most appropriate setting to improve patient outcomes.

The primary goal of any payment reforms in the post-acute care sector should be to improve patient choice, access to services, and health outcomes. In delegating the development of a prototype for a post-acute care prospective payment system, Congress should direct CMS to avoid financial incentives that jeopardize patient choice and access or lead to inappropriate underutilization of medically necessary rehabilitation services. We will not know whether bundling payments truly has the potential to enhance care and save money until a viable bundled payment model is adequately tested within the Medicare population.

The Continuing Care Hospital

AMRPA believes that reforms with the greatest chance of long-term success do not use reimbursement to try to override clinical decision-making, but instead seek to align payment changes with efficiencies in the delivery of care. The Medicare Shared Savings Program is a salient example of effectively integrating care delivery and payment reforms. The Continuing Care Hospital (CCH) model has the potential to be another success story, moving from a provider-oriented to a patient-centered payment system and improving care coordination. Rather than relying on the outdated Post-Acute Care Payment Reform Demonstration, Congress should direct the Center for Medicare and Medicaid Innovation (CMMI) to promptly implement the CCH pilot, as currently required by statute.

The CCH model focuses admission, treatment, and payment decisions on the needs of the patient and is an amalgam of different care approaches including IRI/Us, long-term care hospitals (LTCHs), and hospital-based SNFs organized to deliver intensive rehabilitation therapy and critical medical components. Defining the episode of care as a CCH stay plus the 30 days following discharge allows CMS to begin testing a viable post-acute care bundled payment model before having to report to Congress on

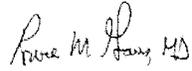
³ DOBSON DAVANZO & ASSOCIATES, ASSESSMENT OF PATIENT OUTCOMES OF REHABILITATIVE CARE PROVIDED IN INPATIENT REHABILITATION FACILITIES AND AFTER DISCHARGE (unpublished manuscript, May 2014).

prospective payment and other post-acute care payment reforms. Although CMMI does not require additional legislation to launch the CCH pilot – which it is already statutorily mandated to do – Congress should ensure that implementation occurs swiftly as an important step in evaluating viable post-acute care payment reforms.

Conclusion

AMRPA supports careful consideration of new payment models, but not as a façade for cutting costs and shifting spending to other parts of the Medicare program at the expense of patients' full recoveries from serious illness and injuries. We look forward to working with the Energy and Commerce Committee in thoroughly vetting proposals to reform the post-acute care sector and advancing proposals that take this charge seriously. We thank you once again for the opportunity to submit this statement in the Subcommittee's record.

Sincerely,



Bruce M. Gans, MD
Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

Mr. GREEN. Thank you and the ranking member for holding this hearing. I want to thank Dr. Miller for your testimony.

Our district in Houston is home to world-class hospitals and community oncology centers. We know that Medicare payment rates often vary for the same service provided to similar patients in different settings such as physicians' offices, hospital outpatient departments or for specific services across any of the post-acute care settings. While at the first glance it seems unclear why Medicare would pay different rates for the same service, we have heard justifications from both sides of the debate on whether to maintain these differential payments or to move to site-neutral payments. For example, Representative Rogers has a bill that would equalize reimbursements for oncology services received by patients in a hospital outpatient department with those by patients in freestanding oncology clinics. The hospital outpatient departments tell us that their higher rates are necessary because their additional payments help pay for the hospital standby capacity, access to care for low-income patients, efforts to improve care coordination and community outreach. The freestanding clinics have said the payment system is inadequate, causing them to close their doors, limiting access to care for critically ill patients and increasing total costs as hospitals are buying them up.

Mr. Miller, as you represented a nonpartisan research-driven policy body, I am interested to hear your perspective on the matter. I understand that MedPAC has given a considerable amount of thought to the subject of site neutrality and establish criteria for when it is appropriate to equalize payments across settings including considering beneficiary access and cost-sharing. Could you further describe the Commission's thinking on the topic?

Mr. MILLER. Yes, and I actually appreciate the question, and this is in some ways what Mr. Burgess and I were almost up to.

So the way the Commission has approached this in the ambulatory setting, the principal is, assuming and assuring actually that the beneficiary has access and quality, Medicare should seek the most efficient setting, and so that is the motivation, and the other motivation is, we have seen a tremendous amount of data that suggests that it is heading out of the lower payment setting.

But by the same token, and while there are people in the hospital industry who probably are suspect, we want to be sure that the hospital's core mission, particularly for emergency room and standby services, are not undercut, and so the criteria that we worked through was, is the service provided in a physician's office frequently so it is safe to do outside of the hospital, is the risk profile of the patients the same, is the unit of payment the same, and is it not associated with emergency services, and so then using that criteria, we said what services fit this criteria. So we are not just sort of sweeping through and saying pay it all, you know, the same, we are saying you need to be careful to protect the core mission of the hospital but also undercut this incentive that is pulling things out of the physician setting and approaches the practice. So that kind of high level, that was the criteria that we were using.

And again, you know, I have gotten some other questions of what about oncology, what about cardiology. We didn't approach it as a specialty or service line. We stepped back and said what meets

these criteria and then let things hit the criteria and said OK, these are the ones that qualify.

Mr. GREEN. Has MedPAC given thought to aligning payment rates between hospital outpatient departments and physicians' offices for other types of ambulatory management, cardiac surgery? I think you answered that.

What further analysis or information would you need before being able to comment on the appropriateness of equalizing these payment rates between OPDs and the physician offices for oncology services? Are there any concerns you can share with us now?

Mr. MILLER. I mean, what I do want to point out before I switch right back to your question is, we looked at this also for equalizing rates between ambulatory surgery centers and hospital rates for a set of surgeries that also met these criteria that I went through. On the oncology side, I am willing, as a matter of questions for the record, to try to give you a more detailed answer of what oncology services came in under our criteria and the kinds of things one might want to think about if they were to look further into it, but I am not really tooled up to do that right this second.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman. I appreciate it. And I guess you almost got to one of the things I was thinking. You have to make sure the same person walking into an outpatient isn't the same person walking into a hospital because if you are going to do the same procedure—

Mr. MILLER. Absolutely.

Mr. GUTHRIE. What if the person is diabetic? Therefore, they say we need to do this in the hospital so you do have paying for capacity for some availability there, so that is just something that I was thinking that you kind of addressed that before.

Mr. MILLER. And the Commission does take that seriously, and there was statistical work done by a couple of people behind me who said do these patient profiles look statistically different than each other, and if they did, they weren't included in the basket of services that we would focus on.

Mr. GUTHRIE. And do you think some of it could be cost shifting such as an outpatient clinic wouldn't have—they obviously don't have emergency room, and I hear, I think somebody mentioned it earlier that people come in with Medicaid and Medicare particularly don't pay the cost of—it may pay the cost of service for a cardiogram more than if you got it outpatient but it is also keeping the emergency room open. I am not saying that is the right way to do it.

Mr. MILLER. I think I understand your question, and if not, immediately redirect because I want to use your time carefully. We also took that into consideration. We said if a service is provided in an emergency room setting on, you know, any significant basis, then again, it was out of the mix, and our point was, we don't want to undermine the core mission of the hospital to have emergency standby services. The Medicare payment rates, since those services are very—or those costs are very direct—staff, equipment, that

type of thing—those are built into higher rates that go to the hospitals for those services. We share that concern. We tried very hard to work around that and make sure we weren't undercutting that.

Mr. GUTHRIE. OK. Thanks. And a couple of questions I wanted to ask about the—going from a lot of people in private practice settings into hospital settings. There was a Merritt Hawkins survey that asked the students in the final year of medical school. In 2001, 3 percent said they would rather work for a hospital than private practice. Now it is 32 percent. I know there are other factors but what extent do you think the Medicare practice expense payment disparities are responsible for the decline in attractiveness?

Mr. MILLER. OK. I think this question is much more complex, but before I blow past it, I do want to say, and I think there were some other comments along these lines, it is very hard to ignore that if a hospital is approaching a practice and saying I have, you know, revenue that I can buy out your practice and make it very lucrative to you, that is going to be important. But to the extent that we have talked to physicians, talked to hospitals, talked to folks like that, we hear a very, you know, kind of mixed story on the part of the physicians. There does seem to be a generation of physicians who are saying care has become very complex, and I don't mean that in a negative way. It means, you know, we all have to think about the patient much further and broader than my own sets of services that I am providing. It takes more coordination, it takes more understanding of the patient's medical record, and some physicians will say a larger organization that will take that overhead off of my hands and allow me just to focus on the care is where I want to be, and by the way, I would like some predictable hours and that type of thing. And then you run into physicians who are saying this is the wrong direction to go, I want to run my own practice. So I think these currents are more complex than any one factor, but I don't think we should dismiss the notion that either in the private sector or Medicare if the revenues are there, then it is going to be hard to say no to them.

Mr. GUTHRIE. That is a good question, it leads into my next one, because you said whether Medicare or private sector. Does the private sector, private payers mimic the Medicare site-of-service disparity of payments?

Mr. MILLER. I wouldn't use the word "mimic" but the outcome is the same. It is generally true that the private sector pays more in those settings than in the physician setting.

Mr. GUTHRIE. So they get similar discounts between hospitals and ambulatory areas?

Mr. MILLER. There are similar price differences between physician office and hospital settings—lower, higher.

Mr. GUTHRIE. Well, I appreciate that, and I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Hi, Mr. Miller. Thank you for being with us today.

I know some of my colleagues have asked about the 340B program, and I believe you said that at this point it is being looked

at. Is that correct, that you are not ready to kind of weigh in on it?

Mr. MILLER. I haven't even taken the Commission through it because the research is really still very much at the formative and staff level.

Mrs. ELLMERS. OK.

Mr. MILLER. But we are not oblivious to the issue. That is the point I would like the committee to know.

Mrs. ELLMERS. Great. Well, I will tell you, it is a concern of mine because I do believe that there is—just as you are looking into the issue, I think there is a lot of gray area there, and I think that this is one of those issues where we are looking at health care savings and dollars that are being saved, and of course, first and foremost, patient access to care, especially those who are in an economic disadvantaged situation. These programs are very worthwhile and we need to make sure that they are sustainable. Unfortunately, I am not at this point sure that we really know where those dollars are going, and I think that is something that we need to get to the bottom of and, with that, I will just follow up by saying that about a year ago, last year, Commander Pedley, the head of HRSA, had stated that she was not sure where the dollar savings, where the money was going, and I think that that is a significant statement because if the Government doesn't know—I mean, shouldn't the Government know where these dollars are going and how they are being utilized?

Mr. MILLER. I think so.

Mrs. ELLMERS. And there again, I will just get back to the issue of—

Mr. MILLER. But I want to assure you that we wouldn't look at that issue strictly as a savings issue. We would look at it as a program integrity issue, assurance for beneficiary access, assurance that we are paying fairly and then, you know, if that turns out that we are letting dollars go out the door that shouldn't go out the door, then that will be the outcome.

Mrs. ELLMERS. I think, you know, from my perspective, it is an issue of, are those dollars going to the care that those patients who require charity care. You know, if the hospital is a 340B hospital, are those dollars truly going where they are supposed to go, and certainly not ever thinking that a hospital would be playing games, but I think if there is a wide and a very gray area there, I think that the hospital would utilize them as they need to, and I think that might be something that we need to work on into the future.

And I will go back too to the cancer care in the hospital setting versus the outpatient or ambulatory care setting. This is something that I am very, very concerned about. I am very concerned about the cost issue with chemotherapy drugs, especially since the sequester went into effect. We have seen a number of cancer clinics that are in our communities basically closing their doors or being bought out by hospitals and many of them will cite that it has to do with the Affordable Care Act, which is an issue, but then on top of it, the sequester has created a very difficult situation for them to continue in private practice, and in fact, I will add to that by saying that just in my hometown of Dunn, North Carolina, oncology practice was just purchased by a hospital, and now hospital

care will be given at that clinic. The good news is, they will be there in Dunn. The bad news is, now the care is going to be much more costly.

So there again, it gets back to the issue of how do we justify that if that the patient receives the care in the hospital, which is wonderful care, great care being provided by health care professionals, but then if they go to a more convenient area that they have come to appreciate and know and feel comfortable receiving their treatment, now that cost is going to go up simply because the hospital now owns that practice.

Mr. MILLER. You have defined the problem extremely well. This is the way the Commission is thinking about it, and the only other thing I will say with respect to your comments is, the Commission has been on record as saying that, you know, the sequester is not a good policy and what we try to offer the committees of jurisdiction on a daily basis in every one of our reports are more thoughtful policies to get you where you need to be without having to do the across-the-board type of stuff.

Mrs. ELLMERS. Well, thank you, Mr. Miller. I truly appreciate it, and thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

All right. We will begin a second round. Dr. Burgess, do you have questions?

Mr. BURGESS. Thank you, Mr. Chairman. So Mr. Miller, we have been talking today about payment disparities across different sites of service, the inpatient hospital, outpatient department, ambulatory surgery centers and physician offices. Outpatient departments and ambulatory surgery centers have similar requirements to participate in the Medicare program and to be licensed at the State level, and both arguably provide high-quality care. Can you discuss the cost benefit of increasing payment rates in certain outpatient settings?

Mr. MILLER. I am really sorry. There was some distraction over there, and I apologize.

Mr. BURGESS. That is all right. Let us wait until it calms down.

All right. So we have various settings where can be administered. Ambulatory surgery centers, physician offices, outpatient departments, they all have similar requirements to participate in the Medicare program and to be licensed at the State level. All provide high-quality care. Can you discuss the cost and benefit of increasing payment rates in certain outpatient settings?

Mr. MILLER. Increasing payment rates in certain outpatient settings?

Mr. BURGESS. Hospital outpatient department versus an ambulatory surgery center.

Mr. MILLER. And the question is, should there be differences in the rate or—

Mr. BURGESS. No. Are there differences in the rate, and then, what is the benefit that occurs because of the differences in the rate?

Mr. MILLER. OK. I am sorry. There are differences in the rate. I think a figure to carry around in your head is, there is about an 80 percent difference between the rate in an OPD and an ASC, just to focus on that for a second, and I think what the Commission ex-

plored, we made recommendations with respect to some services between a physician office and the OPD but over here on the ASC side, we also did some research where again we used some criteria, which I will take you through, but I understand your time is limited, where we tried to identify similar patients, you know, services that could safely be done in both settings and then said that there is the opportunity to lower the payment rate on the OPD side to the ASC rate. There were 12 services and in total it is in the neighborhood of \$500 to \$600 million annually.

Mr. BURGESS. And in this movement from a hospital to an outpatient setting, does that potentially free up the hospital time and space for use for other patients who have a greater degree of acuity who wouldn't be satisfactory to be serviced at an ambulatory surgery center?

Mr. MILLER. Yes, I think that is our—in constructing the criteria, that is what we are trying to assure.

Mr. BURGESS. Let me ask you this. In January of this year, the committee voted on recommendations around site neutrality for 66 ambulatory payment classifications. Is the Commission looking at other classifications or codes?

Mr. MILLER. At least for the near term, the blocks that we have looked at are evaluation and management codes. The 66 APCs that you just mentioned, we have done analysis on that, and we have done analysis on 12 APC/OPD codes, and that is the exchange we just had one second or so ago. At the moment, this is kind of where we are. I am not 100 percent sure how much more we will do but the Commission sort of has to figure out what its cycle is going to be for the upcoming cycle. And so at the moment, this is what we have and this is where we are. It would be hard for me to point to specific things that we are going to do beyond this.

Mr. BURGESS. Mr. Chairman, thank you for the consideration. I will yield back to you.

Mr. PITTS. The Chair recognizes Mr. Green, 5 minutes for questions.

Mr. GREEN. Mr. Miller, I am concerned when we are discussing payment that we make sure to appropriately account for complexities and differences among patients. I believe if we move forward to reform the post-acute care setting, we should also be looking to make sure that we are appropriately adjusting provider payments to reflect those beneficiary risk scores. Can you discuss the issue: Do you believe risk adjustment is an appropriate issue to focus on?

Mr. MILLER. Yes, and in all of our work, when we talk about bundling and we talk about differences, you know, creating either bundled payments or when we talk about moving towards a more unified post-acute care payment system or if we talk about assuming risk at more of population level, say an accountable care organization, we spend a lot of time talking about the need to measure differences in risk, and I will say something a little more specific about that, and then also to make sure that we construct quality measures so you sort of backstop the patient in a couple of ways. You make sure that the payments that go out the door are adjusted in a way that they reflect the relative risk of I took this patient, you took that patient, and then we have quality metrics to sort of

make sure that the patient is getting the kind of care that they need.

I think in the post-acute care setting, there are lots of discussions beyond things like diagnosis and the kinds of comorbidities, things like functional status, cognitive status, physical status, that thing of thing, which probably need to come into the mix in order to make the measurement more accurate, and we have got some discussion and focus on that in our work.

Mr. GREEN. You may have already answered that a little bit just now, but what steps do you take, for example, in developing a bundled payment would appropriately account for the differences? I think you just answered that one.

Mr. MILLER. And again, I think it is this two-prong thing: try and get the risk adjustment as best as you can get it and then have a set of quality metrics to stand by the beneficiary to make sure that they are getting the necessary care that they need.

Mr. GREEN. OK. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Hi, Mr. Miller. I am sorry for running in and out.

Mr. MILLER. No problem.

Mr. CASSIDY. So reading your testimony and listening to it, how much is—obviously is we are building through a hospital-based practice, I assume that is all Part A.

Mr. MILLER. And we are talking about outpatient here, and so this is B.

Mr. CASSIDY. So the facility fee would be Part A, wouldn't it, and the procedures oriented, so if they order an EKG and it is a hospital, it is still Part A, correct?

Mr. MILLER. No, it is still B. I am sorry.

Mr. CASSIDY. Oh, really?

Mr. MILLER. Yes.

Mr. CASSIDY. OK. Well, that helps me.

Now, it also seems, though, in some of the testimony from others suggest that as we migrate towards these hospital-based practices, we are increasing costs for both Medicare and for the beneficiary.

Mr. MILLER. That is right.

Mr. CASSIDY. Now, if you have an accountable care organization, it obviously would increase the cost basis of their care if you have hospital-based services. Fair statement?

Mr. MILLER. That is correct.

Mr. CASSIDY. It almost seems that this is driving up the cost of health care, frankly. I mean, so if you will, it almost seems as if the more we emphasize or induce hospital-based accountable care organizations to acquire practices, i.e., it increases their profitability and increases their cost basis, we are inducing increase and expense both to beneficiaries and to the Medicare program.

Mr. MILLER. That is correct.

Mr. CASSIDY. So we actually have a set of policies which are working in the exact wrong direction if our goal is to decrease cost to beneficiaries and to Medicare.

Mr. MILLER. Yes, that is correct, and the only modification or addendum that I would say to that is, to the extent that you have

prices for the same service on the outpatient side that look like this relative to the physician's office, you are creating an economic incentive to move in that direction. End of sentence. Next sentence. But of course, there are core hospital services——

Mr. CASSIDY. Core, yes, I get that totally.

Mr. MILLER. OK.

Mr. CASSIDY. I am a physician by the way.

Mr. MILLER. We are saying the same thing.

Mr. CASSIDY. Yes, absolutely, but that is, I think, lost in this debate, that we have created a law which is going to drive up cost. Just the behavioral economics of it is such that we are going to create these.

Let me ask you something else.

Mr. MILLER. Yes, we are trying to make sure that it is not lost in the debate.

Mr. CASSIDY. And I appreciate that. Thank you.

Now, also I am very interested in the 340B program, and you may decide that you may or may not wish to comment on this, but to what degree—I will read this, because it was prepared for me but I asked it to be. In the last few weeks, a report by the IMS on global oncology trends as well as other things shows that there is a different cost for Herceptin in different sites of service, that if you have a 340B hospital oncology-based program, that the delta between what they are, you know, charging and paying is such that it creates a competitive advantage relative to community oncologic services. Any comment upon this?

Mr. MILLER. And I really apologize. I am not deep on that. There were a couple other questions on this. The only thing I can offer you is the Commission is aware of this issue and I have some work going on but it is very developmental at this stage. I haven't even taken it out in front of the Commission. So the only comfort I can give you is, we are not tone deaf. We understand that that is going on. We will start looking. We are looking at it.

Mr. CASSIDY. Now, let me ask you then, with my minute and 30 left, if I go to the behavioral economics, there is a sense in which if you put something at two-sided risk, you may mitigate the incentives to increase cost but let me ask, if you put somebody at two-sided risk, they get the upside but also swallow the downside, and they start off with a higher cost basis because they have acquired physicians' practices, particularly, say, orthopedics and hearts. I don't know this. I am asking. Going forward, if they begin to discharge those practices, those procedures to the outpatient setting, do they continue to get the profitability? Did you follow that?

Mr. MILLER. I think I followed it. So I think you probably have a couple of questions in there, and just for purposes of discussion, let us frame it in the context of an accountable care organization. So if an accountable care organization is hospital-based and they have engaged in a lot of this, then arguably—and they get attributed patients in a way for purposes of this conversation occurs, then yes, arguably, they would have a higher base. And so that raises questions which are bigger than a minute 30 but the Commission has been talking about over time how the Medicare program should be looking at that phenomenon.

Mr. CASSIDY. But going forward, if they then take this hospital-based practice and they sell it and it now becomes an outpatient and they begin to now that which was originally conceived at a higher cost basis they are now putting at a lower cost, do they consider—do they continue to get that delta or will the payments ratchet down?

Mr. MILLER. It is theoretically possible that by moving people back, as you used in your example, to a lower cost setting, they could show a better performance. In other words—

Mr. CASSIDY. So that would be an artificially conceived better performance? It would be merely arbitraging the regulations and the site of service?

Mr. MILLER. That is right, but remember, we are talking about a very hypothetical situation.

Mr. CASSIDY. Oh, man, it is not going to be hypothetical, Mr. Miller. I can promise you that.

Mr. MILLER. And I didn't mean to imply that. There is two different, you know, ASC ACO programs, and exactly how the baselines are set get a little bit technical. But what I do want to leave you with is, the Commission is thinking about these phenomena and how to think about setting those basements over time so these kinds of phenomena don't get away from the program. Theoretically, what you have set up there, yes, I see your point.

Mr. CASSIDY. I yield back, and I thank you very much.

Mr. PITTS. The Chair thanks the gentleman. That concludes the second round. Members will have follow-up questions. We will submit those to you in writing. We would ask you to please respond promptly.

Mr. MILLER. OK.

Mr. PITTS. Thank you very much, Mr. Miller. That includes the first panel. We will take a 2-minute break as the staff sets up for the second panel.

[Recess.]

Mr. PITTS. We will reconvene. Everyone can take their seats. Our second panel, I will introduce in the order which they will speak. First, we have Ms. Barbara Gage, Managing Director and Economics Study Fellow, Engelberg Center for Health Care Reform, the Brookings Institute. We have Dr. Barry Brooks, Partner, Texas Oncology, and Chairman, Pharmacy and Therapeutics Committee, the U.S. Oncology Network. We have work Dr. Reginald Coopwood, President and CEO of Regional Medical Center at Memphis; Dr. Steven Landers, President and CEO of Visiting Nurse Association Health Group; and finally, Mr. Peter Thomas, Coordinator, Coalition to Preserve Rehabilitation, and Principal at Powers, Pyles, Sutter and Verville.

Thank you all for coming. You will each have 5 minutes to summarize. Your written testimony will be made part of the record.

Ms. Gage, we will start with you. You are recognized for 5 minutes for your opening statement.

STATEMENTS OF BARBARA GAGE, FELLOW, ENGELBERG CENTER FOR HEALTH CARE REFORM, THE BROOKINGS INSTITUTION; BARRY D. BROOKS, CHAIRMAN, PHARMACY AND THERAPEUTICS COMMITTEE, THE U.S. ONCOLOGY NETWORK; REGINALD W. COOPWOOD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, REGIONAL ONE HEALTH, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION; STEVEN LANDERS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE ASSOCIATION HEALTH GROUP; AND PETER W. THOMAS, PRINCIPAL, POWERS, PYLES, SUTTER & VERVILLE, P.C., ON BEHALF OF THE COALITION TO PRESERVE REHABILITATION,

STATEMENT OF BARBARA GAGE

Ms. GAGE. Thank you, Chairman Pitts and distinguished members of the committee. I appreciate the opportunity to testify today on payment reforms for Medicare post-acute care. I have been studying these issues for a very long time and have led much of the research that underlies this work.

Post-acute care is a very important issue for the Medicare program. Almost 40 percent of all hospital discharges go on to post-acute care, so that is a key point that I want to drive home. We heard a bit about the expenses associated with it.

Second, the patients who are in the acute care hospital for similar conditions we know are often discharged to different settings, and the information that we have leaves us a little unclear as to whether they are actually different in terms of their medical complexity or their functional complexity or cognitive, although some of our results suggest that is the case.

Third, the standardized assessments developed as part of the post-acute care payment reform demonstration showed that these patients could be measured consistently and reliably across post-acute and acute care settings, and once done, that would allow us to answer several questions, many of which came up today, with the same type of hospital patient discharged to alternative settings. We know that some of that varies by geographic area and the availability of beds but some of it may also vary by medical functional and cognitive status. Secondly, did the patient outcomes differ depending upon the site of care.

So why should patients be measured in a standard way? That is a basic issue to answering these questions. As noted in your figures, you can see that almost one in five beneficiaries who are admitted to the hospital each year and about 40 percent are discharged from there into the post-acute care setting. Figure 1 is a little messy but it shows what a Medicare patient—their trajectory of care, and it underscores how these answers are not simple. People have different issues and attend different sites. So the sites include long-term care hospitals, inpatient rehab hospitals, skilled nursing facilities and home health agencies, all of which provide nursing and therapy services in their sites. Among the 37 percent of the PAC users who are discharged from the hospital to home health, 39 percent of them continued on to additional services, so an episode of care is not just one discharge, it is a continuation. The SNF admissions also tended to use multiple PAC services. Of

the 42 percent who were discharged first to a NSF, 77 percent continued on to additional services, and about 23 percent of these cases return to the hospital while another 32 percent were discharged from the SNF to home health for additional services.

The probability and the type of post-acute care service used at hospital discharge can be partially explained by the reason for hospitalization, but as shown in figure 2, the types of cases that were most likely to use post-acute care were patients who had had joint replacements among the top five reasons for an admission to the hospital in Medicare, or stroke populations. However, the factors distinguishing what type of PAC setting would be used were less clear, and as you see on figure 2, the shares of these patients who were discharged to a SNF, 37 percent were home health with 36 percent with another 19 percent discharged to inpatient rehab, so it is not that there is a little bit of variation going on. Conversely, medical cases such as pneumonia and congestive heart failure were less likely to continue to post-acute care. Only about 33 percent of these cases go from the hospital to post-acute care, but when they went, they were most likely to go to SNF or home health, which have very different costs.

The probability of being readmitted to the hospital also varies by the reason for hospitalization, and as shown in figure 3, joint replacements may have a very small share who are re-hospitalized in that 30-day window because we know technically they are healthier if they were strong enough for that surgery. But over 30 percent of the stroke, the pneumonia and the heart failure cases are readmitted during that window, and again, claims provide very little information to explain these differences. Additional information about health status is available from patient assessment data. In the Medicare program, assessment data is submitted in the inpatient rehab hospitals, through the MVS and the SNFs, through Oasis and the home health, and more recently, through the LTÉC care in the long-term care hospital, and each of these assessment tools contain the same types of information including measures of their medical status, their functional status and their cognitive status as well as social support information collected by discharge planners. The same type of information is collected in the hospital as patients are admitted and managed through the stay. Despite these similarities in practices, few of the tools use the same items to measure the patient complexity. All are measuring primary and comorbid conditions, pressure ulcer staging, cognitive impairment, mobility and self-care limitations, many of the things we have been talking about this morning, as well as documenting whether the patient will need assistance at discharge, whether they live alone, and the types of medications they are on but without using a common language to measure these characteristics, a patient's progression cannot be measured across the episode of care.

So findings from the post-acute care payment reform demonstration, this came up this morning, this was a major initiative mandated by Congress in the Deficit Reduction Act of 2005, which required CMS to develop standardized assessment items for use at hospital discharge and at admission and discharge to the post-acute care settings. The standardized assessment items were critical to allowing comparisons of the patient acuity, the differences

in the complexity across settings, and more importantly, to answer these questions about whether outcomes differ across the setting. First you need to be able to know that you are looking at the same patient in terms of complexity.

Mr. PITTS. Could you begin to wrap up, please?

Ms. GAGE. Yes. The care items were based on the science. They had the input of over 25 associations and each of the clinical communities working with the post-acute care populations and were highly reliable in each of the different settings.

But what do these results tell us about payment policy? That one set of uniform assessment items can be used across acute and post-acute care settings. They were reliable in all the settings. They allowed the differences in patient severity to be documented.

A question about whether a standardized payment system can go into effect now based on the post-acute care payment reform data. We collected assessments on over 25,000 cases over 55,000 assessments in the data set, and while they were adequate for identifying key differences, key drivers of patients associated with one setting or another, there are small numbers of certain types of populations. So collecting the standardized data nationally for 2 years prior to actually finalizing payment systems will increase that sample size and allow you to have stronger numbers.

Why use standardized items across the acute and post-acute settings? Condition severity is independent of setting. Using standard language to measure it in each of the three areas of health status will improve communication and allow data exchange across different IT systems. There is work underway right now by CMS and ONC working with the health IT communities to develop interoperable standards for the care assessment items, which will allow exchangeability even if one system is using a Mac and another an IBM product. CMS also provides the item specifications and the e-specifications, the training, the training materials to all providers who are required to submit assessment data, and the e-specifications are downloaded.

So why should the standardized assessments be collected at the hospitals? The hospitals already collect this type of information but they use different items to do so. A recent review by the American Hospital Association showed that the hospitals under the bundled payments and under the accountable care organizations were trying to predict readmissions but you couldn't compare differences across hospitals because they were all using their own systems. If you standardized the assessment items and include them, you can actually compare outcomes.

[The prepared statement of Ms. Gage follows:]



**“Keeping the Promise: Site of Service Medicare Payment Reforms”
Testimony on the Committee on Energy and Commerce, Subcommittee on Health**

Submitted by
Barbara Gage, PhD, Fellow, Engelberg Center for Health Care Reform
The Brookings Institution | May 21, 2014

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Committee, thank you for the opportunity to testify today on payment reforms for Medicare post-acute care (PAC). My testimony makes a number of points. First, post-acute care plays a significant role in Medicare expenditures and patient experiences during an episode of care. Almost 40 percent of all Medicare hospital cases are discharged to at least one post-acute care setting; of them, many will use more than one PAC service and about 20 percent will be rehospitalized during that episode of care (**Figure 1: Supplemental Materials**). Second, patients who were in the acute hospital for similar conditions may be discharged to different settings depending on the availability of providers in a local market (Gage, 1999; Gage et al, 2005) but it is unclear whether they differ in terms of medical or functional complexity (**Figure 2**) Third, the standardized assessment items developed as part of the Post-Acute Care Payment Reform Demonstration (PAC PRD) showed that these patients could be measured consistently and reliably across acute and PAC settings, and once done, several questions could be answered, including:

- Was the same type of hospital patient discharged to alternative settings depending on geographic area or did they differ in terms of medical, functional, or cognitive status?
- Did patient outcomes differ depending on the PAC setting used after hospital discharge?

Why should patients be measured in a standard way?

Almost one in five Medicare beneficiaries is admitted to the hospital each year; among them almost 39 percent are discharged from the hospital to at least one PAC sites for additional nursing or therapy treatments (**Figure 1**). These PAC sites include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). Many patients continue on to additional

PAC sites after the first service. Among the 37 percent of PAC users who were discharged from the hospital to HHAs, 39 percent continued on to additional services, and of them, the majority were readmitted to the hospital (24 percent of the HHA admissions). SNF admissions also tend to use multiple PAC services. Of the 42 percent of PAC users who were discharged first to a SNF, 77 percent continued on to additional services. About 23 percent of these cases returned to the hospital while another 32 percent were discharged from the SNF to HHAs for additional services during the same episode of care.

The probability and type of PAC service used at hospital discharge can be partially explained by the reason for hospitalization. As shown in **Figure 2**, the types of cases that were most likely to use PAC were patients who had joint replacements or strokes (87 percent and 63 percent, respectively). However, the factors distinguishing what type of PAC setting would be used were less clear; almost equal shares of these patients were discharged to a SNF (37.3 percent) or a HHA (36.7 percent) with another 19 percent discharged to an IRF. Conversely, medical cases such as pneumonia and congestive heart failure were less likely to continue onto PAC (about 33 percent each) but when they went, they were most likely to go to SNF or HH. These analyses were based on claims data which provide very little information on differences in the medical, functional, and cognitive factors that may affect these discharge decisions.

The probability of being readmitted to the hospital also varies by the reason for hospitalization (**Figure 3**). While joint replacements have a very small share being rehospitalized within the 30 day window (14 percent), over 30 percent of the stroke, pneumonia, and heart failure cases will be readmitted during this window. Again, claims data provide very little information to explain these differences in readmission rates. Additional information about patient health status is available from patient assessment data. In the Medicare program, IRFs are required to submit IRF-PAI data; SNFs are required to submit MDS data; HHAs are required to submit OASIS data; and LTCHs are required to submit LTCH-CARE data to CMS. Each of these assessment tools contain the same types of information, including measures of medical status, functional status, and cognitive status as well as social support information collected by discharge planners. This same type of information is collected in acute hospitals as patients are admitted and managed throughout the stay. Despite

these similarities in practice, few of the tools use the same items to measure patient complexity. All are measuring primary and comorbid conditions, pressure ulcer staging, cognitive impairment, mobility and self-care limitations, as well as documenting whether the patient will need assistance at discharge, whether they live alone, and the types of medications they are on at discharge. But without using a common language to measure these characteristics, a patient's progression cannot be measured across the episode of care.

Findings from the Post Acute Care Payment Reform Demonstration

The Post Acute Care Payment Reform Demonstration (PAC PRD) mandated in the Deficit Reduction Act of 2005 required CMS to develop standardized assessment items for use at hospital discharge and at admission and discharge to PAC settings. Standardized assessment items were critical to allowing comparisons of patient acuity across settings. And more importantly, standardized items were needed to examine whether outcomes differed when similar patients were treated in alternative types of PAC settings.

The standardized CARE items were based on the science behind the existing assessment tools, the input of stakeholders from across the continuum as well as the input of clinicians from each of the five levels of care, including acute, LTCH, IRF, SNF, and HHA settings. Over 25 national associations and provider groups participated in the selection of the best items for providing uniform measures of medical, functional, and cognitive status across settings. The resulting item set, the Continuity Assessment Record and Evaluation (CARE) was tested for reliability in each of the five settings. The results showed that patient characteristics could be measured uniformly and reliably across settings. For example, prior to this, pressure ulcers were documented differently in each setting although the clinical leaders in this area, the National Pressure Ulcer Advisory Panel, (NPUAP) recommended standard ways to document these conditions. CMS has since replaced the disparate pressure ulcer items in the four mandated assessment tools with the standardized items recommended by NPUAP.

Standardized measurement approaches are critical to enable patient comparisons across settings, both in terms of complexity and outcomes achieved. Using the standardized assessment data, the PAC PRD results showed that the types of patients admitted to each PAC setting had both similarities and differences; in

other words, some types of patients were treated in more than one setting and some types of patients tended to be in only one setting. For example, **Figure 4** shows that certain characteristics were common across LTCH, IRF, and SNF admissions and were associated with higher resource use in all 3 settings. Functional impairment, including both mobility and self-care skills, were associated with higher resource needs, particularly in the SNF and IRF settings where they were among the top 3 factors predicting resource intensity. Still, even in the LTCH setting, they were second only to ICU length of stay, ventilator use, and restricted oral intake. On the other hand, the ICU length of stay, ventilator use, and restricted oral intake were only found to be significant predictors of resource intensity among the LTCH cases, distinguishing these populations from those admitted to the other two inpatient PAC settings.

This table is also useful for distinguishing between SNF and IRF admissions. While both settings have increased resource intensity associated with mobility and self-care function, and higher comorbidity scores, and poorer endurance, SNFs were more likely to have resources associated with cognitive functional impairment and expression while IRF cases had higher associations with bowel, bladder and swallowing impairments. These findings highlight the types of patient characteristics that are common across settings while also identifying the distinguishing characteristics in each setting.

Patient similarities across settings can also be seen by the graph in **Figure 5** which show that while the average functional level at admission differs across settings, the range of function at admission overlaps across settings. In other words, on average, LTCHs admit the most functionally impaired populations while HHAs admit the least functionally impaired. However, the wide range of overlapping grey bars suggests that some of the populations admitted to each setting could be similar to those treated in alternative settings.

Figure 6 shows that outcomes do differ across settings for different populations. After controlling for demographic factors, such as age, gender, medical factors such as primary and comorbid conditions, as well as impairments, the results show that musculoskeletal patients treated by HHAs have significantly greater improvements in self-care functions than those treated in SNFs. However, these differences did not remain for patients with nervous system disorders, such as strokes. Conversely, IRFs had better outcomes than SNFs for

patients with nervous system disorders but showed no difference in outcomes for musculoskeletal populations, such as orthopedic populations.

What Do These Results Tell Us About Payment Policy?

One set of uniform assessments can be used across acute and PAC settings to measure patient severity.

- The standardized items were reliable in all five settings, including the acute hospital, LTCH, IRF, SNF, and HHA. Clinical communities appreciated moving to a standard way to measure patient conditions, especially ones based on the stakeholder and clinical input and using publicly-available, scientifically valid and reliable measures, regardless of treatment setting.
- Standardized items allow differences in patient severity across settings to be documented, and allows comparisons of outcomes knowing that the patients have been measured similarly in each setting. Standardized assessment items are necessary for adequate risk adjustment as it allows an “apples to apples” comparison.

Can a standardized payment system go into effect now based on the PAC PRD data?

- The PAC PRD collected data on over 25,000 cases treated in over 200 acute, LTCH, IRF, SNF, and HHA providers. While the data were adequate for identifying key factors that differentiate patient populations and measuring the impact of those factors on resource use and outcomes, some of the less frequent populations have small numbers.
- Collecting the standardized data nationally for 2 years prior to finalizing payment system changes will increase the sample size for less common cases and reduce the uncertainty associated with changes in the payment system, such as those that would occur by replacing non-uniform items with standardized versions of the items in each of the PAC payment systems.

Why use standardized items across the acute and PAC settings?

- Condition severity is independent of setting. Using standard language to measure patient severity in each of the 3 areas of health status (medical, functional, cognitive) will improve communication and allow data exchange across disparate HIT systems.

- CMS and ONC are currently working with the health IT community to develop interoperable standards for exchanging CARE items across disparate electronic health record systems
- CMS provides item specifications, e-specifications, training, and training materials to all providers required to submit assessment data. Vendors can download the e-specifications from the CMS website.

Why should the standardized assessment items be collected at the hospital?

- Hospitals already collect this type of information (see PAC PRD reports). They use a range of items to measure the same concepts as the Federal assessment items. A recent review by the American Hospital Association showed that hospitals are trying to predict readmission rates using these types of items currently in their internal data systems. While their items are analogous to the standardized assessment items, they can only be used to identify which of their admissions are at high risk of rehospitalization. However, because each hospital uses its own version of these items, hospital outcomes cannot be compared across the local market. More importantly, their data cannot be exchanged with other providers treating the patient. This will impede communication and coordination of care efforts common to many of the current system redesign initiatives, such as accountable care organizations, bundled payments, and coordinated care initiatives.
- Many patients choose SNFs and HHAs based on their proximity to home. As a result, one hospital may discharge to a wide range of PAC providers who may not be in their system. Using standardized assessment data will allow the patient record to follow the patient through an electronic exchange of this information.
- Accountable Care Organizations (ACOs), medical homes, bundled payments and other value-based purchasing efforts need standardized items to compare differences in outcomes for each hospital. Otherwise, results may differ due to different definitions of the same complicating factors, such as pressure ulcers, pre-morbid function, cognitive impairments.
- Differences in measurement can contribute to access barriers by allowing individual hospitals to select cases most likely to have a good outcome (or least likely to be rehospitalized). Among the most complex

cases, rehospitalization can be managed but not entirely avoided. Clinicians need to have the ability to document severity in a reliable and valid way so adequate risk adjustment can be used when setting payment and quality requirements.

Thank you for providing me the opportunity to testify today. If you have additional questions, I can be reached via email at bgage@brookings.edu.

Figure 2: Type of PAC Used Varies by Reason for Hospitalization

ICD-9-CM Diagnosis Code	Discharge for PAC	Percent Using PAC	Percent of Discharges Discharged to PAC				
			IRF	SNF	Home	Other	
001-999	14,291	97.3	0.2	18.4	37.3	33.7	7.4
014 Extremity	4,882	44.3	1.9	34.4	34.0	18.7	8.5
018 Respiratory System Infection	4,876	32.9	1.2	1.8	47.1	37.4	13.2
020-029 Mental Disorders	3,842	37.8	1.1	28.5	53.9	7.1	3.4
030-039 Infectious Diseases	2,439	32.3	1.6	2.3	34.4	52.4	11.3
040-049 Circulatory System	2,396	42.3	1.7	2.1	63.8	23.1	8.1
050-059 Digestive System	1,844	45.2	1.6	1.6	55.2	23.9	12.9
060-069 Nervous System	1,737	34.8	0.7	3.0	53.7	32.8	12.1
070-079 Endocrine System	1,683	52.3	2.9	3.3	52.0	27.9	9.9
080-089 Musculoskeletal System	1,445	15.9	1.2	2.1	42.1	42.8	11.2
090-099 Female Reproductive System	1,437	48.4	4.4	4.4	32.2	52.3	2.9
100-109 Male Reproductive System	1,270	46.2	4.3	1.9	51.3	26.0	8.8
110-119 Urinary System	1,250	44.8	1.3	1.3	50.0	33.7	4.8
120-129 Eye	1,209	34.7	1.6	1.9	21.2	45.2	11.6
130-139 Ear, Nose & Throat	1,064	51.3	0.7	3.7	54.7	12.6	6.8
140-149 Skin	1,027	33.3	1.2	2.2	34.4	32.9	9.3

Source: Gage, et al. Examining post-acute care relationships in an integrated hospital system, ASPe.

Notes:

- Probability of using PAC varies by reason for hospitalization — rehabilitation cases have higher share using PAC, medical cases have lower share using PAC
- Same type of hospital cases may be discharged to more than one setting — rehabilitation cases have large shares discharged to IRF and SNF while medical cases have large shares discharged to SNF and HH

Figure 3: Readmission from PAC by Index DRG

Index Sample of PAC Users	N PAC Users	Mean Episode Payments	Percent with Readmission	Mean Readmission Payments
Overall Sample of PAC Users	170,236	\$10,025	30.5	\$18,536
Index Sample of PAC Users (Top 10 DRGs for PAC Users)				
314 Primary Care/Preventive Services	18,281	\$23,965	14.3	\$12,952
314 Primary Care/Preventive Services	4,822	\$23,484	32.4	\$13,426
388 Other Postoperative Procedures	4,873	\$22,475	31.5	\$13,223
127 Other Postoperative Procedures	4,086	\$24,379	43.1	\$17,448
210 High & Special Procedure	3,852	\$16,382	30.4	\$12,919
388 Other Postoperative Procedures	2,499	\$21,118	36.3	\$14,833
320 Other Postoperative Procedures	2,396	\$22,039	31.5	\$13,964
418 Postoperative Care	1,896	\$10,627	33.1	\$13,955
316 Postoperative Care	1,848	\$28,729	38.4	\$18,699
286 Postoperative Care	1,257	\$12,852	33.1	\$13,078

Source: Gage, et al. Examining past acute care relationships in an integrated hospital system: ASPE.

Notes:

Probability of readmission varies by type of case – rehabilitation cases have lower share being readmitted within 30 days, medical cases have a higher share being readmitted within 30 days

Figure 4: Determinants of Resource Intensity
The importance of variables by setting – routine RII

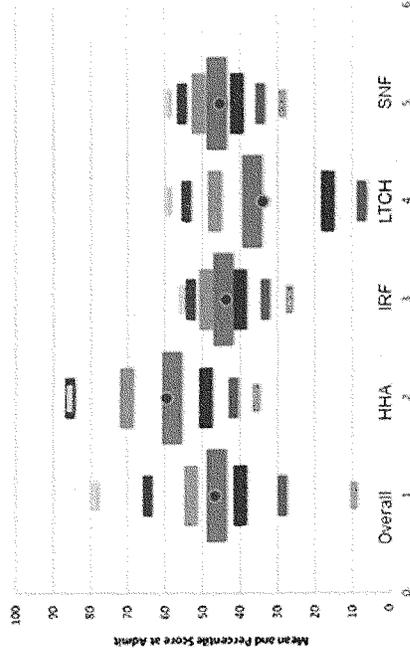
(For the individuals setting models there are similarities and differences in the strongest variables. Motor scores, the comorbidity index and age are highly correlated with resource intensity in each setting, but additional factors vary by setting)

LTCH Model	Score	SNF Model	Score	IRF Model	Score
ICU Days	100.0	Reason Mobility Score	100.0	Challenged dx/Hx/Spns	100.0
Ventilator	29.1	Reason Self-Care Score	86.4	Reason Self-Care Score	92.0
Prn dx Septicsh	25.2	Comorbidity Index	50.9	Reason Mobility Score	77.6
No Intake by Mouth	21.0	Sitting Endurance	44.9	Comorbidity Index	67.3
Reason Self-Care Score	17.3	Cognitive Function	16.5	Age	63.3
Reason Mobility Score	12.1	Expression	12.0	No Intake by Mouth	57.2
Comorbidity Index	12.0	Age	11.2	Sitting Endurance	48.0
Age	8.2	Prn dx Ortho Med	7.5	Bowel Incontinence	23.1
Prn dx Septicemia	6.9	Prn dx Ortho Med Surg	5.1	Prn dx Neuro Surg	23.0
Pressure Ulcer	3.3	Comorb dx Cellulitis	5.0	Expression	25.7
		Bowel Incontinence	5.0	Bowel Catheter	24.0
		Prn dx Kidney Med	5.0	Bladder Incontinence	18.9
				Swallowing Symptoms	18.5

Notes:

- Function (self-care and mobility), comorbidity index, and age are highly correlated with resource need across all settings
- Other factors associated with resource need varied by setting in importance but some overlap also remained
 - LTCHs: infections/septicemia and pressure ulcers
 - SNFs: endurance, cognition affected resource intensity followed by certain medical conditions, incontinence
 - IRFs: endurance, bowel/bladder problems, swallowing symptoms

Figure 5: Unadjusted Self Care at Admit by Provider Type



Key
 HHA: Home Health Agency
 IRF: Inpatient Rehabilitation Facility
 LTCH: Long term acute care hospital
 SNF: Skilled nursing facility

Notes:

- Low Functioning = 0; High Functioning = 100
- Average functional status (red dot) at admission differs by setting with LTCHs admitting the lowest and HHA admitting the highest functioning cases. However, the variation in the range of function at admission overlaps across settings (gray bars)

Figure 6: Effect of Provider Type Adjusted for Case Mix

	Estimate for All Patients (n = 12,065)	Estimate for Musculoskeletal Patients (n = 3,492)	Estimate for Nervous System Patients (n = 1,756)
CHANGE IN SELF CARE			
HHA	4.02** (n = 3,190)	4.35** (n = 810)	2.80 (n = 361)
IRF	3.75** (n = 4,158)	3.10 (n = 1,463)	3.93** (n = 1,096)
LTCH	0.74 (n = 1,968)	-1.91 (n = 122)	0.67 (n = 86)
SNF (referent)	*** (n = 2,749)	*** (n = 1,037)	*** (n = 213)

Case mix variables included demographic factors, primary and comorbid diagnoses, impairments

Notes:

- After controlling for medical conditions, comorbid diagnoses, impairments and demographics, the extent to which PAC patient's improved in their ability to do self care/ADL tasks varied by condition.
- While HHA orthopedic/musculoskeletal patients gained 25 % higher scores than SNF patients, the nervous system/stroke patients improvement was not different than the degree to which SNF patients' improved
- IRF patients' improvement was not significantly different than SNF patients' improvement in musculoskeletal populations but the nervous system populations' was almost 25 % greater than

Mr. PITTS. Thank you. The gentlelady's time is expired.

For the witnesses, we have a little series of lights on the table. It will start green. You will have 5 minutes. When it gets to red, that is 5 minutes, so if you can just keep that in mind and begin to wrap up at the red light.

Dr. Brooks, you are recognized for 5 minutes.

STATEMENT OF BARRY D. BROOKS

Mr. BROOKS. Chairman Pitts, Ranking Member Pallone, thank you for the opportunity to testify on behalf of U.S. Oncology and Community Oncology regarding site-of-payment reforms.

I am Barry Brooks, and for 32 years I have had the privilege of taking care of cancer patients in the community setting. Being an oncology is challenging but deeply rewarding, and I love it.

Americans enjoy the best cancer survival rates in the world. One reason we have the best cancer care is because the network of community clinics that provides state-of-the-art cancer care close to home. Yet in recent years, we have had a sharp decline in community-based cancer care, leaving patients with fewer options and more expensive medical bills. Thanks for recognizing one of the main drivers in the shift of care.

To be blunt, cancer care costs more in hospital outpatient departments and hospital-based care is growing by leaps and bounds. Congressional action is needed to stem the shift of care and the resulting costs incurred to Medicare, taxpayers and patients.

I was pleased to hear Mark Miller's testimony today, and I am glad that MedPAC is weighing in on this important issue. Hospitals play a critical role in cancer care delivery, and I am not going to try to diminish that today, but instead highlight access and cost consequences of an environment that favors hospital-based outpatient care. This unlevel playing field should be fixed by any support of patient choice and access to affordable, quality cancer care.

In the current environment, hospital-based care enjoys numerous advantages over community clinics including up to 50 percent discounts on drugs for the 340B program, tax exemptions, Medicare reimbursement for uncollectable patient responsibilities, Government payments for uncompensated care, tax-deductible private contributions, and the focus of today, higher payments for the same services.

In less than a decade, a third of outpatient cancer care has moved from the community to the hospital. Hundreds and hundreds of clinics have closed and hospitals are aggressively buying up private practice oncology. Many times when this happens, patients see the same physicians, nurses and caregivers in the same offices. The only thing that changes, like mentioned by Representative Ellmers, is the name on the door and the amount charged to Medicare and the patients. In other cases, outlying clinics are consolidated to be closer to the main hospital campus, as mentioned by Representative Rogers. This results in increased travel and hassle for patients undergoing cancer treatment. Either way, patients fighting cancer are burdened by new barriers to access, either financial alone or both financial and geographic. A Milliman study finds that this costs Medicare \$6,500 more per beneficiary each

year, \$623 million total each year, \$650 more out of pocket for each senior cancer patient.

Why should we accept a system that requires the Nation's most vulnerable to pay more for the exact same service in a less convenient setting? Not only do hospitals charge more for the same services, their utilization and overall spending are higher too. An analysis of Medicare data by the Rand Company indicates hospitals spend 25 to 47 percent more on chemotherapy and 42 to 68 percent more on chemotherapy administration. The latest CMS payment rules worsen our problem. The 2014 payment rate for the most common chemotherapy infusion is now 125 percent higher in the hospital than in the community. A recent IMS study calculated prices for 10 common chemotherapy treatments and found hospital charges for those treatments 189 percent more on average than an independent doctor's office. Sadly, they also show that patients who experience these higher out-of-pocket costs are more likely to discontinue treatment altogether.

We know the committee has supported policies to equalize E&M payments across care settings. We strongly support the efforts of Representatives Rogers and Matsui to take an urgent approach for oncology services. There is no reason for different payments for the same outpatient services to depend on whose name is on the door. As proven over the last decade, Government-imposed market advantages will predictably lead to expansion and higher cost centers and corresponding reductions in patient access and increases in patient costs. Members of this committee have introduced and supported legislation that enhances cancer patient access like H.R. 2869 that we are discussing today from Rogers and Matsui, H.R. 800, Whitfield, Representative Green and DeGette, and H.R. 1416 from Representative Ellmers and others. Over 30 members of this committee, 124 in all, have signed a letter to CMS questioning how the administration handled sequestration cuts on our Medicare Part B drugs administered in our office. Given the current reality facing our community oncology offices, if these solutions are not enacted, by this time next year there will be fewer community oncology clinics and more patients will have to travel farther and pay more for the same services.

The world's best cancer care delivery system is struggling. We need your help.

Thank you for letting me testify today. I would be happy to answer questions when it is appropriate.

[The prepared statement of Mr. Brooks follows:]



**Submitted Testimony of Dr. Barry Brooks on
Keeping the Promise: Site of Service Medicare Payment Reforms
Energy and Commerce Health Subcommittee Hearing
May 21, 2014**

Chairman Pitts and Ranking Member Pallone, thank you for the opportunity to testify today on behalf of The US Oncology Network¹ before the Energy and Commerce Subcommittee on Health on *the Medicare Patient Access to Cancer Treatment Act*, H.R. 2869, sponsored by Congressman Mike Rogers and Congresswoman Doris Matsui. Members of the Health Subcommittee have been especially committed to the nation's cancer patients and care providers over the years and many of the Members on this Committee can take credit for policies that have shaped our world-class cancer care delivery system. Thanks for your dedication and support for Americans and their families fighting cancer and for those of us who work to help patients live longer, happier, better lives.

I'm honored to be appearing before the Committee again. My name is Barry Brooks, and for the last 32 years I have spent the majority of my time taking care of cancer patients as a practicing oncologist. On an average day I work 12 hours and treat around 14-20 patients, in addition to the

¹ The US Oncology Network is one of the nation's largest networks of community-based oncology physicians dedicated to advancing cancer care in America. Like-minded physicians are united through The Network around a common vision of expanding patient access to high-quality, integrated cancer care in communities throughout the nation. Leveraging healthcare information technology, shared best practices, refined evidence-based medicine guidelines, and quality measurements, physicians affiliated with The US Oncology Network are committed to advancing the quality, safety, and science of cancer care to improve patient outcomes. The US Oncology Network is supported by McKesson Specialty Health, a division of McKesson Corporation focused on empowering a vibrant and sustainable community patient care delivery system to advance the science, technology and quality of care. For more information, visit www.usoncology.com.

significant administrative duties that come along with taking a leadership role in my practice and The US Oncology Network. Slightly over 40 percent of my patients rely on Medicare and another 5-10 percent are either covered by Medicaid or are uninsured, but throughout the country over 60% of cancer patients rely on Medicare. Many seniors fighting cancer have more complex cases with co-morbidities and many also face difficulties navigating their care. Fortunately, community oncology clinics such as the one where I practice expand access for them with high-quality, state-of-the-art care close to home with lower co-insurance and other costs. So I am proud to be a small part of the most effective and successful cancer care delivery system in the world. And finally, after nearly 100 years of increasing cancer death rates in the United States, we have started to turn the corner in this fight: cancer mortality has fallen by 20 percent from a 1991 peak and cancer patients from around the world seek care here because Americans enjoy the best cancer survival rates in the world.

Despite significant progress in treatment and survival rates you all know that we still have a long way to go in beating this disease. The American Cancer Society estimates that in 2014 nearly 1.7 million Americans will be diagnosed with cancer and more than 585,000 will die of cancer, which is 1 out of every 4 deaths in America.

One of the main reasons cancer care works so well in America is the existence of a network of community based cancer clinics that provide patients with convenient, comprehensive, state-of-the-art cancer treatment close to home. Just a decade ago more than 85 percent of cancer patients were receiving their cancer treatment in community cancer clinics. However, in recent years we have seen a sharp decline in the availability of community based cancer care, leaving

cancer patients with fewer options and higher medical bills. Unfortunately, the crisis in community based cancer care has continued to worsen in the short time since I last spoke before the Committee.

I will use my time with you today to discuss why the nationwide network of community based cancer clinics are under so much strain and, more importantly, to explain how H.R. 2869 is an important first step to relieve this pressure in a way that is beneficial to patients, to care providers, and taxpayers.

I want to preface this by saying that every oncologist nationwide, regardless of where they practice medicine, will tell you that hospitals play a critical role in cancer care delivery, inpatient and outpatient. Each of us wants and expects quality acute care to be available at hospitals when we need it. Nor do I fault the many community oncologists throughout the country who have been forced to accept employment or other arrangements in hospital-based programs. It is not easy to run a vibrant independent practice these days with government-imposed hospital advantages and referral sources often owned by the hospitals as well. My testimony is not intended to diminish their choices or the value of the services they provide. Instead, I want to highlight the predictable, and unfortunately now realized, access and cost consequences to patients and the health system of an environment that financially favors hospital-based outpatient cancer care over the same quality care provided in community cancer clinics. Policymakers need not allow the continued destruction of the community cancer care patients need and prefer in order to continue to support hospital-based care. This unlevel playing field should be adjusted

by those who support patient choice and access to affordable, quality care so that patients have options among provider settings and locations.

Site of Service Shift over Recent Years

In 2005, over 87 percent of U.S. cancer patients received treatment in their preferred community clinic setting. By 2011, that number was less than 65 percent and today it is likely less than 60 percent. Over the past several years, the country has experienced a significant shift of outpatient cancer care delivery from the community to the hospital outpatient department (HOPD). Unfortunately, the data are clear: our world-class community cancer care delivery system is struggling to survive. Since 2008, 1,338 community cancer care centers have closed, consolidated, or reported financial problems; 288 oncology office locations have closed, 407 practices merged or were acquired by a corporate entity other than a hospital, and 469 oncology groups have entered into an employment or professional services agreement with a hospital.²

Also by 2011, a third of Medicare's outpatient chemotherapy and anti-cancer drugs had moved to the hospital setting, a more than 150 percent increase for HOPDs. As a result, Medicare spending on payments for chemotherapy administration services in HOPDs has more than tripled since 2005, while payments to community cancer clinics have actually decreased by 14.5 percent.³ Sadly, the flight from community oncology did not end in 2011. Since early 2012,

² Community Oncology Alliance Practice Impact Report, June 25, 2013. Online at: http://www.communityoncology.org/UserFiles/Community_Oncology_Practice_Impact_Report_6-25-13F.pdf

³ Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2001 for Medicare Fee-for-Service Beneficiaries; The Moran Company (May 2013), available at <https://media.gractions.com/E5820F8C11E80915AE699A1BD4FA0948B628578601655fc9-7f3d-4d9a-80d0-d2f9581673a1.pdf>

there has been a 20 percent increase in clinic closings and hospital acquisitions, which means increasingly more patients are facing reduced access and more expensive care.⁴

Year after year, as I watch colleagues being forced – either for financial or competitive reasons – to merge with a hospital, it has become clear that congressional action is necessary to halt the patient access and cost consequences that come along with the shift to hospital-based care. With reduced access to community cancer clinics, not only are patients forced from their preferred treatment setting, forced to drive further and wait longer, they are also charged more for the same service. In many cases, patients see the same physicians, nurses and caregivers in the same offices and sit in the same chairs, but pay significantly more because of the change in ownership and billing from physician practice to hospital outpatient department. In other cases of consolidation, outlying clinics are closed when they are too remote from the hospital facility to qualify for provider-based billing and purchasing, resulting in increased travel and hassle for patients trying to fight their disease. Patients fighting cancer should not bear the brunt of nonsensical policies that distort the health care system.

Differential Costs and Payment Rates across Outpatient Settings

Recent studies show that the shift to hospital outpatient cancer treatment has reduced patient access and increased costs to the Medicare program, taxpayers and patients. A 2011 Milliman study finds that the cost of treating cancer patients is significantly lower for both Medicare

⁴ Community Oncology Alliance Practice Impact Report, June 25, 2013.

patients and the Medicare program when performed in community clinics as compared to the same treatment in the hospital setting.⁵

The study shows HOPD-based chemotherapy costs Medicare \$6,500 more per beneficiary (over \$623 million) and seniors \$650 more in out-of-pocket spending per patient annually. Keep in mind, the median income of Medicare beneficiaries is less than \$23,000. I ask the Committee today, why would we favor a system that requires the nation's most vulnerable to pay more for the exact same service, just in a different, less accessible setting? Put another way, why would we continually subsidize higher overhead costs and impose higher costs to cancer patients while at the same time underfunding the more efficient lower-cost community cancer offices?

Not only are HOPDs charging more for the same service, their spending is higher when caring for patients with the same diagnosis and stage of cancer. A new analysis of 2009-2011 Medicare claims data by The Moran Company indicates that by a variety of metrics, chemotherapy spending is higher at the HOPD than the physician office despite lower unit payment rates for drugs in the OPDS during that period [it is now equal in both settings at ASP+6% or +4.3% after considering the sequester impact]. Patients receive more chemotherapy administration sessions on average when treated in the HOPD—and the dollar value of chemotherapy services used is meaningfully higher in the HOPD. On a per beneficiary basis, HOPD chemotherapy spending was 25 to 47 percent higher than physician office chemotherapy spending across the 2009-2011

⁵ K. Fitch and B. Pyenson, Milliman Client Report, Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy (Oct. 19, 2011), available

period and HOPD chemotherapy administration spending was 42 to 68 percent higher than physician office chemotherapy administration spending.⁶

In the face of this trend, the Centers for Medicare and Medicaid Services continued to widen the difference in reimbursement for the same services across outpatient settings this year. The 2014 Medicare Physician Fee Schedule rate for one hour of chemo infusion (96413) by intravenous therapy is \$133.26, but the payment rate for the same service under the 2014 Hospital Outpatient Prospective Payment Schedule (HOPPS) is 125 percent higher at \$299.53.

Building subsidies into HOPD payments for cancer care services to cover hospitals' indirect expenses associated with standby services does not appropriately target the added resources to those services. It also distorts pricing for outpatient services that require the same level of resource commitment regardless of the site of care. Such subsidies in combination with other site-specific Part B drug payment and policy issues have been major contributors to the rapid increase in hospital employment of physicians in general, and oncologists in particular.

Just this month, the IMS Institute for Healthcare Informatics released a study on innovations and cancer costs in the US. The report shows that Americans are increasingly paying higher prices because more patients are being treated by oncologists whose practices have been bought by hospitals, which may charge double or more for the same treatments. The report's authors calculated prices for 10 common chemotherapy treatments and found hospitals charged 189 percent more on average — or nearly triple — what the same infusions would cost in an

⁶ Cost Differences in Cancer Care Across Settings, The Moran Company, August 2013.

independent doctor's office. The higher charges, which hospitals say are needed to support overhead and administrative costs, can often translate into steeper out-of-pocket costs for insured patients.

The May 2014 IMS report calculated that for commonly used cancer drugs, the average increased cost to the patient is \$134 per dose if received in a hospital outpatient setting rather than in an oncologist's office. Alarming, the report also mentions that patients who face higher out-of-pocket costs are more likely to drop out of treatment, citing a study showing that a bump of as little as \$30 in co-pays caused some breast cancer patients to skip or discontinue care. These types of discrepancies in reimbursement throughout oncology and other specialties greatly advantage hospital outpatient departments and subsidize their relative inefficiency. And if fighting to complete therapy and survive the disease weren't enough, cancer patients experience a financial toxicity associated with their diagnosis: they are 2.65 times more likely to file for bankruptcy than people without a cancer diagnosis.

MedPAC Recommends Site Neutral Payments

In its June 2013 report, the Medicare Payment Advisory Commission (MedPAC) recommended leveling the playing field for outpatient services, including oncology services. In the report, MedPAC highlighted the large disparities in payment in outpatient settings and noted that the payment variations across settings should be addressed quickly due to the fact that current disparities have created incentives for hospitals to buy physician practices, driving up costs for the Medicare program and for beneficiaries in a manner that cannot be easily reversed later. The report says alignment of outpatient reimbursement makes sense for services that can be

successfully and safely carried out in a physician's office, are infrequently provided in emergency rooms, involve average patient severities that are no greater in the hospital outpatient setting than in freestanding offices, and do not involve significant differences in resources as a result of packaging under the HOPPS.⁷ Most cancer care services fit this description.

The history of successful community-based cancer care establishes that successful, cost-effective outpatient oncology services do not require hospital-based delivery. MedPAC concluded that hospitals should not automatically be paid higher rates for services appropriate for delivery in physician offices simply because hospitals incur higher indirect costs associated with other services that must be provided 24 hours a day and 7 days a week, or provided to patients with higher acuity or additional legal requirements that largely focus on emergency room and inpatient care.⁸

340B Drug Discount Program and Other Hospital Advantages

In addition to these code and service specific payment differentials outlined by MedPAC, hospitals enjoy other advantages relative to government policies around Medicare Part B drugs that push more patients and physicians into that setting. Approximately, one third of US hospitals purchase chemotherapy drugs through the 340B program at discounts of up to 50 percent, typically more than 30 percent below the Medicare reimbursement rate in the physician setting.⁹ For 340B hospitals, the margin on Medicare drugs is over 30 percent, where for community clinics the margin is zero to negative 2 percent. With these high margins, it is no

⁷ MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013).

⁸ 78 *Fed. Reg.* at 43296.

⁹ OIG Memorandum Report: Payment for Drugs Under the Hospital Outpatient Prospective Payment System OEI-03-09-00420, October 22, 2010. Online at: <http://oig.hhs.gov/oig/reports/oei-03-09-00420.pdf>

wonder that drug spending is increasing so rapidly in the hospital outpatient setting and that care is moving in that direction.

Another long-standing challenge with Medicare payments for Part B drugs and services concerns the patient coinsurance responsibility and other out-of-pocket costs that many seniors are unable to pay. It is rare for physician practices to be able to collect the entire Medicare allowable rate for Part B drugs and services because of the 20 percent coinsurance obligation facing beneficiaries, often for very expensive therapies. The experience of the US Oncology Network has been that approximately 25 percent of the coinsurance amounts (approximately 5 percent of the Medicare allowable) due to practices are uncollectible and end up as a direct expense of the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.

A substantial portion of hospitals also operate without the burden of federal and state taxes. In contrast, community cancer clinics receive no reimbursement for uncompensated care, must pay taxes and must pay the full cost of all the drugs administered to patients, even when they cannot collect the full reimbursement from payers and patients.

Conclusion

The National Cancer Institute estimated that there were approximately 13.7 million Americans living with cancer in the U.S. last year. About 8 million of those are over the age of 65 and approximately half of all cancer spending is associated with Medicare beneficiaries.¹⁰ As the baby boomers continue to reach 65 these numbers will only increase. Now is the time for Congress to act to ensure the future of community based cancer care and stop the site of service shift into more costly hospital outpatient departments.

When clinics close their doors or raise their prices, access to care is compromised for all cancer patients, but especially for vulnerable seniors. This shift to hospital-based care doesn't just reduce access to care for cancer patients, it also increases costs to Medicare, taxpayers and patients. These differences are even greater for care covered by private insurers. There is no clinical justification for migration of outpatient cancer care to the hospital setting. Patients don't want to be in a hospital and there is no practical or clinical advantage for driving care into a more expensive setting.

The US Oncology Network knows the Committee is familiar with this facet of the problem and has supported policies to equalize evaluation and management (E/M) payments across care settings. We strongly support the current bipartisan efforts by Congressman Rogers and Congresswoman Matsui to take an urgent approach to site-neutral payment for oncology services. At a time when access and cost issues are intertwined, we appreciate their collective belief that payment amounts be commensurate with actual services provided, not the site of care. Preferentially paying higher amounts in certain settings will predictably lead to the expansion of

¹⁰ Mariotto AB, et al. Projections of the Cost of Cancer Care in the United States: 2010–2020, *J Natl Cancer Inst* 2011;103:1–12. Online at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107366/>

higher cost centers. The result will be further increases in the cost of cancer care for those who pay for it – patients along with private and government payers.

In fact, a strategy I encourage the Committee to explore would be to move toward the creation of a single outpatient fee schedule for all outpatient services regardless of the provider. As hospitals continue to acquire and purchase primary and specialty physicians, the cost of health care services will continue to rise while creating serious access problems nationwide. By removing the incentive for hospitals to purchase physician practices and charge more, physicians and hospitals will be able to compete on a level playing field on the basis of quality and cost, allowing patients to have greater options in their health care delivery system that cost less.

Additionally, I would just like to highlight and thank the several Members of this Committee that have written legislation and signed onto letters that assist in preserving community cancer care. Specifically, H.R. 800, sponsored by Congressmen Whitfield, Green and DeGette and 65 additional co-sponsors, would result in a more accurately aligned Part B drug reimbursement by removing any discount between the manufacturer and distributor that is included in the ASP formula but not passed on to the provider. Over 30 Members of this Committee signed a letter to CMS questioning how the Administration handled the sequestration cuts on Medicare Part B drugs, while Congresswoman Ellmers introduced H.R. 1416 and garnered 112 co-sponsors which would remove the outsize impact of the administration's decision to apply the 2 percent sequestration cut to not only the services community oncologists provide, but also the underlying cost of cancer-fighting drugs physicians purchase on behalf of Medicare and administer to seniors. This cut is in effect a 28 percent cut to the payments Medicare makes to community

clinics for handling, storing, mixing and preparing drugs for administration, and in conjunction with the prompt pay discount problem and uncollectible patient coinsurance, makes Medicare Part B drugs at best a break even proposition for community cancer clinics. On behalf of all of the community cancer clinics struggling to keep the doors open, I urge the Committee and the Congress to enact these three pieces of legislation to sustain community oncology. Without your action, cancer clinics will continue to close and care will continue to shift to the more expensive, less accessible hospital outpatient setting. Americans fighting cancer will experience diminished access to care, and patients, payers and taxpayers will pay more.

The primary purpose of a doctor is to relieve suffering. My oncologist colleagues across the country and I are doing our best, but in order to continue to provide the world's best cancer care here in America, we need your help. Once again, thank you again for the opportunity to address the committee. I am happy to answer any questions the committee has regarding my testimony.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Coopwood, 5 minutes for opening statement.

STATEMENT OF REGINALD W. COOPWOOD

Mr. COOPWOOD. Good morning, Chairman Pitts, Mr. Green, and—

Mr. PITTS. Can you poke the little button on there? Yes. Thank you.

Mr. COOPWOOD. Good morning. Chairman Pitts, Mr. Green, and distinguished members of the subcommittee, I am Dr. Reginald Coopwood, President and CEO of Regional One Health in Memphis, Tennessee. I am here today on behalf of the American Hospital Association's 5,000 member hospitals, and I appreciate this opportunity to share with you and your colleagues the hospital field's perspective on site-neutral payment proposals.

Regional One Health, which serves a three-State area, includes a nationally acclaimed level I trauma center, a level III neonatal intensive care unit, the only American Burn Center-certified burn center in our region, and a high-risk obstetrical referral center. Annually, there are more than 100,000 outpatient visits to our health system. We have four community primary care sites and more than 32 subspecialty services are provided in our outpatient facilities. Nearly one in four people in Memphis live in poverty, and the city has a very low health ranking.

Americans rely heavily on hospitals to provide 24/7 access to emergency care for all patients and to respond to every conceivable type of disaster. These roles are not specifically funded. Instead, they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care across various settings including hospital outpatient departments. Even though this is the case, some policymakers have endorsed proposals that would make payments for service provided in a hospital the same as when a service is provided in a physician's office or ambulatory surgery center. These proposals have a number of problems and would have devastating consequences for Medicare patients in the communities you represent.

First, it is important to know that hospitals are already losing money providing outpatient services to Medicare beneficiaries. The Medicare Payment Advisory Commission data says that hospitals' outpatient Medicare margins are a negative 11.2 percent. To make matters worse, if site-neutral payment proposals under consideration by some policymakers were enacted, it would result in outpatient payment department Medicare margins of nearly negative 20 percent. This could force hospitals to curtail these vital outpatient services and threaten seniors' access to care.

Second, hospitals have additional financial burdens as compared to a physician's office. As was previously mentioned, this is due to the need to provide the community with 24/7 emergency capacity. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements. For example, hospitals must comply with EMTALA, a State hospital licensure requirement, the voluminous Medicare conditions of participation and Medicare cost reporting requirements, among others.

Finally, when compared to patients treated in physicians' offices, hospitals serve more medically complex patients as well as higher percentages of patients who are eligible for both Medicare and the Medicaid program and a higher percentage of disabled patients.

At Regional Medical Center, our hospital-based outpatient departments play an integral role in the health system's ability to fulfill our mission: to improve the health and well-being of the people we serve and to ensure that vulnerable patients have access to effective health care services which provide patients access to acute care services, a retail pharmacy that offers a sliding fee scale, medical interpretation services, surgical facilities, nutrition and diabetic care, as well as rehabilitation services. Providing these services has helped us reduce costly emergency department utilization, reduce hospital readmissions and improve care continuity for vulnerable patients and their health outcomes. The AHA has estimated that the proposed changes to hospital outpatient payments would reduce Medicare payments to my hospital, Regional One Health, by approximately \$8 million over the next 10 years. Our ability to continue to improve the health status of our communities by ensuring that individuals have access to the right level of care at the right time in the right setting would diminish if those cuts were made. We also would have to evaluate our existing services as well as any plans to expand our service capacity. This would disproportionately impact the most vulnerable and elderly patients that we serve.

Again, I appreciate your invitation to share the hospital's perspective on site-neutral payment policies with the committee. I urge you to exercise caution and not to propose any recommendations to Congress that would dramatically reduce payments to hospitals until a complete analysis and debate has occurred. Ensuring adequate payment for all services will allow hospitals to continue to provide access to care for all patients. Thank you.

[The prepared statement of Mr. Coopwood follows:]



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**Testimony of the
American Hospital Association
before the
Health Subcommittee
of the
Energy and Commerce Committee
of the
U.S. House of Representatives
on**

“Keeping the Promise: Site-of-Service Medicare Payment Reforms”

May 21, 2014

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,200 inpatient rehabilitation facilities (IRFs), 288 long-term care hospitals (LTCHs) and 850 hospital-based skilled nursing facilities (SNFs), thank you for the opportunity to testify today and provide the hospital perspective on site-of-service payment proposals.

My name is Reginald Coopwood, M.D., and I am the president and CEO of Regional One Health located in Memphis, Tennessee. Our health system, which serves a three-state area, includes a nationally acclaimed Level I trauma center, a Level III neonatal intensive care unit, the only American Burn Association certified burn center in our three-state region and a high-risk obstetrical referral center. Annually there are more than 100,000 outpatient visits to our health system.

The AHA and the hospital field are extremely concerned about site-neutral payment proposals that would pay hospitals at the payment rates of facilities with lesser clinical capabilities. Americans rely heavily on hospitals to provide 24/7 access to emergency care for all patients, to serve as a safety-net provider for vulnerable populations, and to respond to every conceivable type of disaster. These roles are not explicitly funded; instead they are built into a hospital’s overall cost structure and supported by revenues received from providing direct patient care across various settings. Therefore, the AHA urges Congress to reject site-neutral payment policies for hospital outpatient departments (HOPDs). Our detailed comments below explore these issues as well as post-acute care site-neutral payment proposals.



SITE-NEUTRAL PAYMENT PROPOSALS FOR HOPDS

Policymakers are considering a number of site-neutral payment proposals. They include capping HOPD payments for evaluation and management (E/M) services at a residual of the physician fee schedule (PFS) payment; capping HOPD payments for a specific set of 66 payment categories at a residual of the PFS; capping HOPD payments for 12 surgical procedures at the ambulatory surgical center (ASC) payment level; redistributing the payment for administration of chemotherapy services by raising payments to private practice oncology clinics; and reducing payments to HOPDs.

There are specific problems with each of these site-neutral payment proposals, which are discussed below, but the unifying issue is the proposals seek to pay less for specific treatments while expecting the hospitals will be able to continue to provide the same services at the current level. However, the Medicare Payment Advisory Commission (MedPAC) has found that HOPD Medicare margins are negative 11.2 percent, thus hospitals are already losing money providing these services to beneficiaries. In addition, hospitals are subject to significant regulatory and quality requirements, none of which would be lowered under the proposed payment reductions. Enacting the three main site-neutral payment proposals would result in HOPD Medicare margins of *negative 20 percent* – an alarming level that could force hospitals to curtail these services and threaten seniors' access to care (see Attachment A).

EVALUATION AND MANAGEMENT (E/M) SERVICES

A 2012 MedPAC recommendation would cap "total" payment for non-emergency department E/M services in HOPDs at the rate paid to physicians for providing the services in their private offices. However, in the 2014 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) collapsed the 10 separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement MedPAC's recommendation. MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy.

MedPAC had estimated that this recommendation would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

Given CMS's sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC's ill-advised prior recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. However, even if it is possible, the AHA strongly opposes such an approach because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients;

- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity; and
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

Like the other site-neutral proposals, the E/M cuts would create even greater shortfalls in Medicare payments and would hamper hospital-physician care integration. Teaching and safety-net hospitals would be hardest hit by the proposed E/M cuts. While the overall cut to U.S. hospitals would be 2.8 percent, impact data from before CMS changed the E/M visit coding structure show that the impact for major teaching hospitals would be a 5.8 percent cut, and urban, public safety-net hospitals would face a 4.9 percent cut. Hospital-based clinics at teaching and safety-net hospitals provide services that are not otherwise available in the community to vulnerable patient populations. The costs in these hospital-based clinics are higher due to greater regulatory requirements, more medically complex and chronically ill patient populations, stand-by capacity costs related to offering emergency department and other services 24 hours a day, 365 days a year, and also the costs of unreimbursed “wrap-around” services.

An AHA analysis of Medicare data demonstrates that patient severity for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly 24 percent higher in HOPDs than in physician offices. HOPDs serve a higher percentage of patients who are dually eligible for both Medicaid and Medicare than physician offices. HOPDs also serve a higher percentage of disabled patients.

66 AMBULATORY PAYMENT CLASSIFICATIONS

MedPAC has recommended broadening the application of its site-neutral payment policy for HOPD services to an additional 66 payment categories beyond its March 2012 recommendation to cut payment for 10 E/M services. Overall, the impact of these cuts would be very significant. MedPAC analysis shows that cuts to these services would decrease Medicare outpatient payments by 2.6 percent, or \$1.1 billion per year. When combined with the E/M cuts already recommended by the commission, the site-neutral payment policies would impose deep cuts of \$2 billion per year on routine outpatient services that are integral to the service mission of hospitals. Together, they would reduce Medicare outpatient payments by 5.5 percent, and reduce hospitals' Medicare outpatient margins from a negative 11.2 percent in 2011 to a negative 17.7 percent, all else being equal.

In its discussions regarding expansion of the site-neutral payment policy to additional ambulatory payment classifications (APCs), MedPAC considered whether the impact on hospitals would be lessened because hospitals employ many physicians practicing in HOPDs and, therefore, collect both the physician fee and the hospital facility fee. Supported by comments from MedPAC staff, some concluded that the hospital would not receive just the residual amount provided under MedPAC's site-neutral payment policy, but instead would be paid at least as much as a physician would receive under the Medicare PFS if the same service had been furnished in a physician's office.

The AHA disagrees. First, hospitals incur the costs of providing services whether or not the physician is employed. When the physician is employed, the hospital also must pay the

physician for his or her services. Second, only a minority of physicians are employed by hospitals. According to 2012 data from the American Medical Association and AHA, only 19 percent of physicians (excluding interns and residents) are employed by community hospitals. While the number of employed physicians is increasing for the reasons MedPAC cited in its March 2012 report, the increase is modest, only 6.5 percent between 2011 and 2012. Thus, in most circumstances, HOPD services are often furnished to beneficiaries by physicians who are not employed by the hospital. In these cases, if MedPAC's policy were implemented, the hospital's payment in full would be the residual amount provided under MedPAC's site-neutral payment policy.

Hospitals also disagree with an assertion made by some MedPAC commissioners and staff that it is common practice for hospitals to charge non-employed physicians for the use of hospital facilities while also billing Medicare directly for the hospital's facility fee. In the discussion, it was stated that hospitals had an opportunity to mitigate the decline in Medicare revenue from the commission's site-neutral payment policy by negotiating with the non-employed physician to split the total Medicare revenue from this.

Our understanding based on practices in the field and regulatory requirements is that in the case of non-employed physicians furnishing services in a HOPD, the physician bills for his or her professional services under the PFS, the hospital bills the facility fee under the hospital outpatient PPS, and there is no splitting of the physician's Medicare payment with the hospital. Splitting Medicare money as suggested would, at a minimum, be viewed as inappropriately double billing the facility fee. Additionally, law enforcement would, more likely, view the exchange as creating a high risk of abuse and lead to scrutiny under the Stark law and anti-kickback statute.

PAYMENT AMOUNTS SHOULD BE SET APPROPRIATELY

MedPAC's site-neutral recommendations have assumed that the Medicare PFS payment rate somehow reflects the correct rate to pay for outpatient services, when, in fact, it is difficult to determine how well Medicare PFS payment rates reflect the actual costs of specific services. It is fair to say that the differences in the payment rates for similar services across ambulatory settings are largely artifacts of the very different and complex methodologies that Congress enacted and that CMS implemented under the outpatient PPS and the PFS.

But outpatient PPS payments are generally based directly on hospital data – audited cost reports and claims data – and have been found by MedPAC to be significantly below cost. In contrast, physicians are not required to report their costs to Medicare; therefore, their costs cannot be compared to payment. Further, the PFS, and specifically its practice expense component, is based on voluntary responses to physician survey data held flat for years due to the cost of various physician payment “fixes.” While the commission's discussion centered on whether, as a prudent purchaser, Medicare should refrain from paying more for a service in the HOPD setting than in the physician office setting, it is equally correct to question whether payment is adequate in the setting that is paid the lower amount.

HOPD PAYMENTS ARE THE RELEVANT COMPARISON

Most of the impact data presented at MedPAC meetings on site-neutral payment masked the extent of the cut to outpatient payments by presenting impact data based on overall Medicare payments – including inpatient and post-acute services – and not separately for outpatient payments. This presentation of impact runs counter to MedPAC’s stated preference against cross-subsidies in payment, which would require looking at each payment system separately. The AHA believes that outpatient payments are the relevant base to consider when proposing outpatient cuts.

In looking at the impact across groups of hospitals, MedPAC presentations showed the combined impact of their site-neutral proposals would be higher for rural hospitals than other hospitals because of their greater dependence on outpatient revenue. However, this analysis was an *underestimate* because the focus on overall Medicare payments, not outpatient payments, likely masks the impact across hospital groups, as some hospital groups, including rural hospitals, generally provide a greater share of outpatient services.

HOSPITALS’ EMERGENCY RESPONSE CAPACITY WOULD BE ENDANGERED

As stated above, hospitals are not physician offices and play a very different role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs and offering myriad other services to promote the health and well-being of the community. While many of these services also are offered by other health care providers, three are unique to hospitals:

- The provision of health care services, including specialized resources, 24 hours a day, seven days a week, 365 days a year;
- Caring for all patients who seek emergency care, regardless of ability to pay; and
- Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent an essential component of our nation’s health and public safety infrastructure. Medicare beneficiaries and the public consistently express concern that cuts to hospital payments could mean fewer nurses and longer waits in emergency departments. The public also values the safety-net that hospitals provide and expects them to be open 24/7 to serve patients and their families.

Despite its importance, the standby role is not explicitly funded. Until a patient arrives with an emergency need, there is no payment for the staff and facility to be “at the ready.” The AHA report, *Prepared to Care*¹, outlines the many elements of stand-by capacity that allow hospitals to respond to emergencies ranging from multi-vehicle car crashes to hurricanes and terrorist attacks. Recent events like Hurricane Sandy and the Boston Marathon bombings serve as a reminder that we, as a society, need this response capacity. Direct funding for this capacity is limited, and federal funding for the Hospital Preparedness Program declined by about 50 percent between fiscal year (FY) 2003 and 2014. While these funds are very much appreciated by

¹ Prepared to Care. available at <http://www.aha.org/research/reports/preparedtocare.shtml>

hospitals, they do not come close to meeting the costs of maintaining stand-by capacity and responding to disasters.

Please realize that without adequate, explicit funding, the stand-by role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices or any other type of provider.

HOPDS TREAT HIGHER-SEVERITY PATIENTS, FACE GREATER REGULATORY BURDENS

MedPAC staff has proposed a principle stating that patients should have access to settings that provide the most appropriate level of care. Hospitals agree. Hospitals want patients to receive care in the appropriate setting and note that community physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. We fear that with a significant reduction in payment, this may no longer be an option or fallback for community physicians.

In addition, hospitals face significantly higher regulatory requirements than physician offices. While many of these requirements help to ensure a higher level of quality and patient safety, they all impose additional costs. Attachment A highlights these regulatory differences, which include complying with the Emergency Medical Treatment and Active Labor Act (EMTALA), state hospital licensure requirements, the voluminous Medicare conditions of participation, and Medicare cost reporting requirements, among others. The higher costs associated with these regulations are legitimately reflected in higher Medicare reimbursement for services furnished in HOPDs compared to free-standing physician offices.

H.R. 2869, REPRESENTATIVE ROGERS CANCER TREATMENT PAY EQUALIZATION

This bill purports to ensure the availability of chemotherapy services by increasing the payments physicians receive to administer chemotherapy to cancer patients in private practice oncology clinics. However, the bill actually accomplishes this by cutting cancer treatment payments for HOPDs. The consequence of this legislation would be to limit access to chemotherapy services for many cancer patients who now receive their treatment in the outpatient setting of their community hospital.

Hospitals care for all patients who seek emergency care, regardless of their insurance status or ability to pay; maintain standby disaster readiness capacity in the event of a catastrophic occurrence; and treat patients who are too sick and require more complex services than those treated by private physician practices. In addition, HOPDs provide services to all Medicare and Medicaid patients. This is not the case for private physician practices.

Recent media reports detail how private practice oncology clinics are turning away Medicare patients². Other reports highlight that it is the high cost of chemotherapy drugs that are the most

² Washington Post, April 3, 2013, "Cancer clinics are turning away thousands of Medicare patients. Blame the sequester." <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/03/cancer-clinics-are-turning-away-thousands-of-medicare-patients-blame-the-sequester/>

significant driver of cancer treatment costs.³ While HOPDs are seeing an increased number of patients, part of that is because private practice oncology clinics primarily serve those patients that are well insured and provide generous payments, and are declining to care for Medicare beneficiaries. In fact, analyses demonstrate that HOPDs serve patients with more complicated conditions or a higher case-mix, and do not refuse to treat Medicare and Medicaid patients.

Some people have incorrectly claimed that the 340B Drug Pricing Program, which provides discounted outpatient drug prices for safety-net providers, is a main driver of consolidation in the oncology field. Larger market forces have influenced independent oncology practices to merge with their community hospitals. Hospitals are strengthening ties to each other and physicians in an effort to respond to new global and fixed payment methodologies, as well as incentives for improved quality and efficiency, implementation of electronic health records and care that is more coordinated across the continuum. The 340B program is a vital part of the nation's safety net, gives patients better access to drugs they need for their care and helps hospitals enhance care capabilities by stretching scarce federal resources. As drug prices continue to rise,⁴ this program becomes even more critical to vulnerable patients and communities.

As stated above, hospitals face many challenges to maintain the full panoply of services that the public expects to receive when they are sick and need care 24/7 – challenges that are not confronted by private practice oncology clinics. Increased demand for specialized services, staffing shortages, diminishing financial support from Medicare and Medicaid, capital expenses, increased accreditation requirements, and greater expectations for emergency preparedness are just a few of the challenges that hospitals are facing. H.R. 2869 would exacerbate the stress on hospitals and on cancer patients.

POST-ACUTE CARE SITE-NEUTRAL PAYMENT PROPOSALS

The AHA supports efforts to bring meaningful reforms to the post-acute care field to ensure patients' continued access to medically necessary services. The AHA approves of the cautious exploration of site-neutral payment policies that apply exclusively to patients who are clinically similar and can commonly receive post-acute care services in different post-acute care settings. However, to achieve true site-neutrality by paying equally for equal care, regardless of location, several crucial policy building blocks are necessary – some of which have not been fully developed.

Fair and equitable site-neutral payment must include equal Medicare reimbursement for like patients. If Medicare pays the same rate for patients treated in two settings, we must be confident that the same payment is applied to similar patients. This assurance is often difficult to

³ Kaiser Health News, May 6, 2014, "Chemo Costs in U.S. Driven Higher By Shift." <http://capsules.kaiserhealthnews.org/index.php/2014/05/chemo-costs-in-u-s-driven-higher-by-shift-to-hospital-outpatient-facilities/>

⁴ Bloomberg, May 7, 2014, "Cancer Doctors Join Insurers in U.S. Drug-Cost Revolt." <http://www.bloomberg.com/news/2014-05-07/cancer-doctors-join-insurers-in-revolt-against-drug-costs.html>

achieve given the high acuity and medical complexity of many beneficiaries. Further, different health settings admit largely distinct populations of patients and fill unique clinical roles. As the AHA discussed in an April 2014 letter to MedPAC (Attachment B), accurately matching patients by severity across care settings is very complex and requires more than grouping cross-site patients based on their principle diagnosis from the prior hospital stay. In addition, any post-acute care site-neutral proposal must be risk adjusted across settings. However, unfortunately, risk-adjustment efforts are still under development. Finally, any site-neutral payment proposal must provide a level playing field for Medicare regulations across the affected settings.

LTCH CRITERIA

In the Bipartisan Budget Act of 2013, Congress authorized stringent new criteria for long-term care hospital (LTCH) payment that will bring major reform to the LTCH field. The new criteria fall somewhere between the position that was promoted by AHA and the proposal that was being developed by CMS. Beginning in October 2015, LTCH cases that fail to meet these new criteria will be on a site-neutral basis, a far lower rate that is comparable to payments for general acute care hospitals. Approximately one out of two current LTCH cases will drop to the lower “site-neutral” payment rate. The new proposal is very complex, as recognized by CMS in its recent proposed payment regulation for FY 2015, and the AHA is closely studying the new LTCH-inpatient hospital site-neutral reform and will be sharing further feedback on this framework with members of Congress and CMS next month.

POST-ACUTE BUNDLED PAYMENT

CMS’s bundling demonstration mandated by the Affordable Care Act will soon complete its first stage. Organizations participating in the demonstration are now preparing to move to the next stage, where they will begin to face financial risk. This is the only large-scale bundling project to date that includes post-acute care providers; therefore, this demonstration is an important opportunity to acquire a great deal of information on the clinical, operational and financial considerations of bundling post-acute services. Given the potential value of the early learning from these demonstrations, the AHA has urged Congress to allow and encourage the CMS Innovation Center to share these lessons with the broader provider community.

In addition to the Innovation Center’s work, MedPAC and several members of Congress have developed other proposals to bundle post-acute care payments, including Representative David McKinley’s Bundling and Coordinating Post-Acute Care Act (H.R. 4673). The AHA supports efforts to explore post-acute care only bundled payment models, in addition to other models. And it discourages endorsing a single bundling approach, which would be premature at this time.

IRF-SNF SITE NEUTRAL PAYMENTS FOR CERTAIN PROCEDURES

In March, MedPAC presented potential “site-neutral payment” approaches to reduce IRF rates to “SNF-like” levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, and hip and femur fracture) who are clinically similar and commonly receive post-acute care services in both IRFs and SNFs. Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, we are concerned that MedPAC has not targeted the

appropriate patients. Accurately matching patients across sites is difficult to accomplish and, as the AHA discussed in its April letter to MedPAC (Attachment B), requires more than grouping cross-site patients based on their principle diagnosis from the prior hospital stay.

CONCLUSION

The AHA and the hospital field are appreciative of your consideration of these issues and urge the Committee to exercise caution and not to propose any recommendations to Congress that would dramatically reduce payments to hospitals until a complete, transparent analysis and debate has occurred. Ensuring adequate payment for all services will allow hospitals to continue to ensure access to care for all patients.

In addition, the AHA supports the cautious exploration of post-acute site-neutral payment proposals to ensure patients' continued access to medically necessary services. However, to achieve true site-neutrality by paying equally for equal care, regardless of location, several crucial policy building blocks are necessary – and some of these policy components are still in development. Therefore, we have significant concerns regarding the viability of some post-acute site-neutral payment proposals.

Attachment A

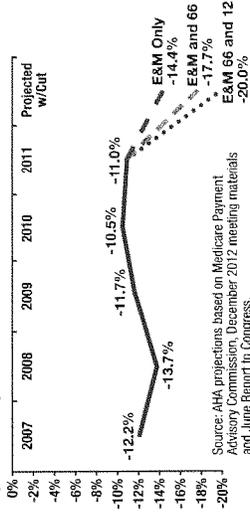
American Hospital Association
Site-neutral Payment Proposals Threaten Access to Care

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety net provider for vulnerable populations, and to have the resources needed to respond to disasters. These roles are not explicitly funded, instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements than other settings.

Yet some policymakers want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center (ASC).

- Lawmakers are considering three site-neutral payment changes that would result in lower payments to hospitals.
 - Paying hospitals for evaluation and management (E/M) services in the hospital outpatient department (HOPD) setting at the physician fee schedule (PFS) amount.
 - Paying hospitals for 66 specified ambulatory payment classifications (APCs) at the PFS amount.
 - Capping hospital payments for 12 proposed APCs at the ASC rate.
- According to the Medicare Payment Advisory Commission's March 2013 report, Medicare margins are already negative 11 percent for outpatient services. **Implementing these policies would further erode HOPDs' Medicare margins, threatening access to care.**

Medicare Margins for Hospital Outpatient Department Services, 2007-2011 and Projected with Proposed Cuts



Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Back up for Complications Occurring in Other Settings	✓		
Disaster Preparedness and Response	✓		
EMTALA Requirements	✓		
Uncompensated Care/Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✓		
Infection Control Program	✓	✓	✓
Quality Assurance Program	✓	✓	✓
Joint Commission Accreditation	✓	✓	✓
Life and Fire Safety Codes	✓	✓	✓
Malpractice Insurance	✓	✓	✓
Admin Staff/Billing	✓	✓	✓
Medical Supplies	✓	✓	✓
Nurses	✓	✓	✓
Space and Utilities	✓	✓	✓

Attachment B



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April 1, 2014

Glenn M. Hackbarth, J.D.
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Dear Mr. Hackbarth:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 1,200 inpatient rehabilitation facilities (IRFs) and 850 hospital-based skilled nursing facilities (SNFs), I write to respond to the Medicare Payment Advisory Commission's (MedPAC) March 6 presentation on site-neutral payment for IRFs and SNFs. During this presentation, MedPAC discussed potential "site-neutral payment" approaches to reduce IRF rates to "SNF-like" levels for patients discharged from a general acute care hospital with one of three conditions (stroke, major joint replacement, hip and femur fracture) who are clinically similar and commonly receive post-acute services in both IRFs and SNFs.

Paying for care in the IRF and SNF settings in a truly site-neutral manner is extremely complex and may be difficult to achieve. Nonetheless, the AHA supports the cautious exploration of a site-neutral payment policy that applies exclusively to patients who are clinically similar and can safely be treated in either setting. However, as outlined below, we are concerned that MedPAC has not targeted appropriate patients and urge the commission to refine its approach. As also outlined below, it is imperative that for services subject to IRF-SNF site-neutral payments, IRFs should face a level playing field with respect to regulatory requirements; that is, for services subject to site-neutral payments, the Medicare regulations requiring IRFs to provide hospital-level care must be removed.

SITE-NEUTRAL POLICY MUST TARGET CLINICALLY SIMILAR PATIENTS

When designing an IRF-SNF site-neutral payment policy, it is critical to ensure that the policy targets clinically similar patients. As discussed by MedPAC commissioners, achieving such an apples-to-apples comparison can be difficult due to the incompatible IRF and SNF patient classification systems. However, we have several suggestions that we believe would help ensure that MedPAC's policy targets clinically similar patients.



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First, when comparing the mix of patients treated in more than one post-acute setting, MedPAC should use the most recent data available to ensure that any resulting policy recommendations reflect current post-acute referral and utilization patterns. The mix of IRF and SNF patients continues to shift due to changes in payment and coverage policies, yet MedPAC data charts from the March presentation used 2011 data rather than the most recent data available. Furthermore, both the presentation and the subsequent discussion cited the Centers for Medicare & Medicaid Services' (CMS) 2011 final report to Congress on the post-acute care payment reform demonstration, which is largely based on data collected from 2008 through 2010. We encourage MedPAC to update its analyses using 2012 data, and again with 2013 data when they become available this fall.

In addition, the AHA urges MedPAC to further refine its analysis to avoid solely relying on the prior acute care hospital discharge diagnosis to find similar IRF and SNF patients. The March presentation compared IRF and SNF data based on patients' discharge diagnosis from the prior stay in a general acute care hospital. However, relying solely on discharge diagnosis to classify patients for the purpose of comparing clinical characteristics has widely recognized limitations because a patient's prior hospital diagnosis is often unrelated to the patient's post-acute diagnosis, which addresses a different recuperative stage in the episode of care. For example, MedPAC estimated that 25 percent of IRF cases have one of the three targeted conditions based on IRF claims data, but these conditions represent only 0.8 percent of IRF patients when grouped by the discharge diagnosis from their prior hospital stay. Furthermore, diagnosis alone – whether a diagnosis from the prior hospital stay or a post-acute discharge – does not reflect functional status, which is critical to post-acute placement decisions. For example, an alternative approach that makes an apples-to-apples-comparison across post-acute settings is the Uniform Data System for Medical Rehabilitation (UDSMR)¹ two-year stroke study that compares IRF and SNF outcomes. To identify comparable stroke patients, the study selects similar patients based on their prior hospital diagnosis *paired with* data from a functional assessment by the discharging hospital that includes physical and cognitive items, and SNF and IRF outcomes data. The compilation of these data elements is needed to achieve a meaningful apples-to-apples comparison of similar IRF and SNF patients.

We also urge MedPAC to incorporate robust risk adjustment into any discussion of IRF-SNF site-neutral payment policy. Comprehensive risk adjustment will be the critical element of a site-neutral payment policy. For example, the March presentation of 30-day readmission rates for IRFs and SNFs for the three targeted conditions should have been risk adjusted.

In addition, as discussed by MedPAC commissioners, we encourage further comparative research on IRF and SNF readmission rates using multiple episode lengths, including 60- and 90-day episodes, to ensure that the longer SNF average

¹ UDSMR is an independent repository of IRF patient assessment data and rehabilitation outcomes.

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lengths of stay are captured. Per MedPAC², one-third of SNF stays exceed 30 days in length. Readmissions patterns for this material portion of SNF stays are not included in MedPAC's 30-day readmissions data, which can be corrected by adding readmissions analyses for longer episodes.

SITE-NEUTRAL PAYMENTS SHOULD NOT APPLY TO 60% RULE COMPLIANT CASES

We urge MedPAC to apply IRF-SNF site-neutral payment policy development efforts only to conditions that fall outside of the "60% Rule" and that are also frequently treated in SNFs, such as lower-acuity joint replacement cases.³ MedPAC should not consider IRF-SNF site-neutral payment policies in isolation from the IRF 60% Rule. Rather, MedPAC should factor in the intent of the 60% Rule when selecting cases to consider for site-neutral treatment. Through the 60% Rule, Congress and CMS have directed IRFs to concentrate their services on 13 clinical conditions. As such, it would be incongruous to reimburse cases with 60% Rule qualifying conditions – such as stroke cases – with SNF-level payments.

MedPAC estimated that industry-wide, in 2013, 60.8 percent⁴ of IRF prospective payment system cases had a qualifying condition. Yet, compliance with the 60% Rule – a facility requirement that each IRF must meet to maintain the IRF payment classification – will become more difficult in 2014. Specifically, in October 2014, new CMS guidance will take effect that reduces by 20 percent the number of ICD-9-CM codes that qualify toward 60% Rule compliance. Applying CMS's narrower set of qualifying codes to UDSMR's fiscal year 2013 IRF patient assessment data⁵ indicates that IRF facility compliance with the 60% Rule presumptive test⁶ would drop by 15 to 20 percent (prior to accounting for behavior change by the field). **The uncertainty about the ramifications of the narrower set of 60% Rule qualifying codes and the concurrent transition to ICD-10 codes, provide further reasons why MedPAC should not add more complexity by proposing to co-mingle the site-neutral payment policy concept with the 60% Rule.**

² MedPAC's March 2012 report to Congress, (page, 197).

³ Only joint replacement cases meeting the following criteria are compliant with the 60% Rule: Patients with a knee or hip-joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay that also meet one or more of the following specific criteria: 1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission; 2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF; or 3) The patient is age 85 or older at the time of admission to the IRF. Joint replacement cases may also comply with the 60% Rule if the patient has a qualifying comorbidity.

⁴ MedPAC's March 2014 report to Congress (p. 249) estimates IRF 60% Rule case compliance based on January 2013 to July 2013 data from eRehabData.

⁵ The UDSMR database contains IRF patient assessment instrument data for greater than 800 IRFs.

⁶ IRFs that fail to meet the 60% Rule presumptive test must then demonstrate 60% Rule compliance through a chart audit of a random sample of medical records.

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STROKE POPULATION IS UNSUITABLE FOR SITE-NEUTRAL PAYMENT

As suggested during the MedPAC commissioners' discussion, the AHA urges MedPAC to eliminate stroke patients from any IRF-SNF site-neutral payment policy at this time. IRFs provide hospital-level care led by physicians, while SNFs provide a less-intensive set of recuperative services that is, on a day-to-day basis, typically provided by nurses, therapists and lower-level aides. The stroke populations treated in both settings are illustrative of the differences between each setting's level of clinical service and each setting's patient mix. MedPAC's March presentation provided several data points demonstrating the higher acuity levels of the stroke patients treated in IRFs, including a higher overall hierarchical condition category risk score, greater ancillary costs and greater prevalence of comorbidities. These gaps between IRF and SNF stroke patients were notably wider than for the other two targeted conditions (joint replacement and hip/femur fractures).

IRF REGULATORY RELIEF MUST APPLY TO SITE-NEUTRAL CASES

The AHA agrees with MedPAC that a level regulatory playing field is an essential component of any future site-neutral payment policy for IRF and SNF cases. Current Medicare statute and regulations require IRFs to provide hospital-level care, and, therefore, they must be paid hospital-level rates. If in the future, IRF and SNF rates for targeted conditions are made on a site-neutral basis, then the service and regulatory expectations for the site-neutral cases treated in IRFs should be lowered. Likewise, such requirements for SNFs should be raised as needed to achieve apples-to-apples parity for site-neutral cases. Regulatory relief for IRF cases receiving site-neutral payment should include: elimination of the three-hour rule, elimination of the 60% Rule, and elimination of other requirements related to providing hospital-level care, such as maintaining physician and nursing levels on par with hospitals.

We appreciate your consideration of these concerns. IRF-SNF site-neutral payment warrants further exploration by MedPAC, but it should proceed with great caution given the challenge of identifying truly similar patients in both settings. If you have any questions, please feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis and Development

Cc: Mark Miller, Ph.D.
MedPAC Commissioners

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Landers, 5 minutes for opening statement.

STATEMENT OF STEVEN LANDERS

Mr. LANDERS. Chairman Pitts, Mr. Green, thank you so much for inviting me to testify today. My name is Steve Landers. I am a family doctor and geriatrician. My background is in home visitation for frail elders and people with disabilities and also in home health agency medical direction. I did my medical training at Case Western Reserve University in Cleveland, Ohio, and my geriatric training at Cleveland Clinic. I later went on to run Cleveland Clinic's home care and post-acute care programs, but the true honor, really the greatest honor of my career has been 2 years ago being able to leave my post at Cleveland Clinic and become a visiting nurse, and I am now the President and CEO of the Visiting Nurse Association Health Group in New Jersey. It is the Nation's second largest independent nonprofit home health organization in the country and the largest in New Jersey. We have been serving our communities for over 100 years.

I have, through my role as a physician, as a medical director, as an administrator, come to admire, frankly, if not revere the work done by home and community health professionals, particularly nurses, aides, therapists, social workers. These individuals help people at the most desperate times in their lives. We know that those receiving Medicare home health services are sicker, older, more likely to be impoverished, more disabled, have higher disease burden than the general Medicare population. Home health services support these patients and families when they are really struggling, living in the shadows with things like Alzheimer's disease, multiple sclerosis, Parkinson's disease. They bring help to help people transition home from the hospital after a stroke, help patients learn to walk again, learn to eat again, support family caregivers in their often taxing job, sometimes 24/7 job, of helping their loved ones at home.

Home health care, it is essential to these families and these individuals, but as importantly, it is also essential for the future of our country. We have 70 million aging baby boomers that want to remain independent at home. This is our country's Sputnik moment for home care and elder care. We need to develop and improve our home care delivery system in order to help these individuals meet their needs and also so that the programs, the Medicare program, Medicaid programs, don't suffer unnecessary financial burdens. Helping people stay home in a win-win where both the patients and families benefit and also the program sees savings.

The current Medicare home care program, it could be so much more. We can do so much more. The current model is limited by overly complex paperwork requirements. We have nurses and physicians spending an inordinate amount of time checking off boxes and filling out forms. The program has struggled with some integrity issues and fraud issues, particularly in aberrant geographies, and that needs to be fixed. There is confusing and unnecessarily limiting homebound requirements that make it difficult for certain people to get home care services. It doesn't make much clinical

sense to me as a physician, and also there are opportunities around technology and care coordination that we are just not achieving yet.

And so that is why I am here to just share my enthusiasm and support for the work being done by Mr. McKinley and your committee on the bundling and coordinating post-acute care initiative because this is a true innovation in how we look at post-acute care, and the flexibility and the removal of barriers to home care and the respect of patient choice that has been engendered in this proposal I think are worthy of commendation, and I am thankful to have the chance to be here to testify in relation to that initiative.

My former boss at Cleveland Clinic says that the future belongs to those who seize the opportunities created by innovation, and I believe that today that we are talking about a proposal that is an innovation in the Medicare program that can help us help more older Americans stay healthy at home in a sustainable way.

Thank you so much for the chance to come today.
[The prepared statement of Mr. Landers follows:]

House Committee on Energy & Commerce – Subcommittee on Health
“Keeping the Promise: Site of Service Medicare Payment Reforms”
Wednesday, May 21, 2014 – 2123 Rayburn House Office Building

Testimony of Dr. Steven Landers, MD, MPH
President & CEO, VNA Health Group

Good Morning Chairman Pitts, Ranking Member Pallone and Distinguished Members of the House Subcommittee of Health. My name is Dr. Steven Landers, and I serve as the President and CEO of the Visiting Nurse Association (VNA) Health Group. Thank you for this opportunity to offer my perspective on how thoughtful Medicare reform can help keep the promise our nation has made to her senior citizens.

By way of brief background, I am a family doctor and geriatrician, with a particular focus on the delivery of therapeutic and palliative care to the elderly in their homes. Following my educational training at Case Western Reserve University School of Medicine and Johns Hopkins University School of Hygiene and Public Health, I served as Director of the Center for Home Care and Community Rehabilitation and Director of Post-Acute Operations for the Cleveland Clinic.

In 2012, I joined the outstanding team at VNA Health Group, the largest not-for-profit home health care provider in New Jersey and the second largest in the nation. For more than 100 years, our organization has served the most vulnerable amongst us — welcoming fragile new babies home, assisting disabled children and their parents, serving traumatically injured adults, delivering complex, specialized nursing services to seniors in the homes, and extending comfort to the terminally ill.

Today, VNAHG serves more than 100,000 individuals annually throughout New Jersey, a privilege we approach in a manner consistent with our tradition of collaboration and connectedness. Since our founding in 1912, our focus has been to serve those who are most vulnerable, through illness or social circumstance, in order that they may have a healthier, more hopeful, and dignified life.

Finally, I serve as Chairman of the Alliance for Home Health Quality and Innovation and serve on the Boards of Directors of the Community Health Accreditation Program, the American Academy of Home Care Medicine, the Greater Newark Health Coalition, the New Jersey Hospital Association Health Research and Education Trust, and the Partnership for Quality Home Healthcare. The Partnership, which I am pleased to represent here today, is a coalition of leading skilled home healthcare providers dedicated to advancing policy solutions that improve the quality of care and life for all home healthcare patients as well as greater efficiency and stronger program integrity for the Medicare program on which they depend.

Given the important focus of today's hearing, I would like to offer my perspective as both a medical professional and home healthcare provider. As this Committee knows, more than 1 million physicians, nurses, therapists and other caregivers across America are working every day to deliver complex medical services to an estimated 3.5 million Medicare home health beneficiaries. What is less commonly known is that this population one of the most vulnerable in our nation. Recently, Avalere Health conducted an analysis of the Medicare Current Beneficiary Survey (MCBS) Access to Care File, a national representative survey of the Medicare population, and found that Medicare home health beneficiaries are older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined:

Avalere Health – Home Health Beneficiary Study: Key Findings¹	Medicare Home Health Beneficiaries	All Other Medicare Beneficiaries
Women	60.07%	53.9%
Beneficiaries aged 85+	24.4%	12.1%
Beneficiaries with 4+ chronic conditions	74.7%	48.5%
Beneficiaries needing assistance with 2+ Activities of Daily Living (ADLs)	23.5%	7.6%
Beneficiaries at or below 200% of Federal Poverty Level (FPL)	66.2%	47.9%
Beneficiaries from ethnic or racial minority population	19.3%	14.9%
Dual-eligible Medicare-Medicaid beneficiaries	26.7%	17.7%

¹ <http://homehealth4america.org/media-center/attach/207-1.pdf>

Members of this vulnerable population include stroke survivors who must relearn how to walk, talk and eat again, as well as senior citizens and disabled Americans with Multiple Sclerosis, Alzheimer's, chronic obstructive pulmonary disease (COPD), and other complex chronic conditions.

Skilled home healthcare is essential to these vulnerable Americans and their families – it addresses their complex clinical needs in the safety and dignity of their homes, enabling them to remain in their community rather than undergo institutionalization. On a personal level, home health professionals also serve as a ray of light in lives of these Americans, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay close to family and community supports.

Home healthcare is also essential to the sustainability of the Medicare program and to the millions of taxpayers who provided critical financing to it. As is well-known, our society is aging – thousands of 'Baby Boomers' are turning 65 every day, and it is projected that the Medicare population will reach 70 million in 2030, just over 15 years from now. This dynamic poses immense challenges to the Medicare program and our nation as a whole. Simply put, we *must* explore creative ways that will enable us to keep the promise made to our senior fellow citizens without putting our nation's fiscal future in jeopardy.

I firmly believe that Home Healthcare has an important role to play, and we stand ready to do so. The driving purpose of home health is to help seniors stay healthy at home. The complex, specialized nursing services we deliver every day not only enables our patients to avoid medical complications and return to health – they avoid institutionalization that would substantially increase costs to Medicare and taxpayers. As has been well documented, home healthcare services are significantly less costly to deliver than those in institutional settings. As a result, it's not just that there's no place like home – there's also no place less expensive than home.

Despite the value that skilled home healthcare professionals already provide and the difference we are making in the lives of our patients, we believe we can do even more for the Medicare program and the nation. Our ability to

do so today, however, is constrained by a variety of challenges that serve as obstacles to greater efficiency and even better outcomes. These constraints include:

- A payment system that is so complex and burdensome it borders on nonsensical;
- Unchecked program integrity issues, especially in certain locations that consistently demonstrate aberrant utilization patterns;
- The requirement that a senior must be so infirm as to be deemed homebound before she or he is permitted to receive medical care at home;
- Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home; and,
- A siloed payment system that impedes care coordination and creates bureaucratic obstacles to quality and efficiency.

It is for these reasons that we so appreciate your development and consideration of reforms that can achieve significant improvement in the lives of vulnerable Americans and the Medicare program on which they depend.

The BACPAC proposal is a compelling example of such positive reform. Through the creation of a clinical condition-specific, site-neutral payment model for post acute care services, BACPAC represents a very important step forward for the Medicare program. In contrast to the challenges which compromise post-acute care today, the BACPAC model is designed to:

- Break down the barriers that today impair quality and produce inefficiency;
- Foster care coordination across today's siloes and among multiple providers;
- Enable mobile and homebound seniors alike to remain where they want to be – home;
- Permit investment in technologies and innovations that will lead to truly connected care; and,
- Achieve significant savings that can be utilized for Medicare program improvements such as reform of the Sustainable Growth Rate (SGR) formula.

Among these laudable attributes are three that I believe deserve specific mention.

First, the approach embodied by BACPAC would foster care coordination in a manner that I believe is essential if the Medicare program is to evolve in the best interests of patients and taxpayers alike. Today, there is too little coordination – a problem that begins even prior to a patient’s discharge from a hospital and which manifests itself in the weeks and months that follow. Too often, the result is the delivery of care that is less effective, more disjointed, and far more costly than is necessary and which is delivered in a setting and manner that is not preferred by the patient and her or his family.

By contrast, the BACPAC model would foster care coordination across today’s post acute care siloes and amongst a broad array of participants, including the hospitalist and discharge planner, the patient’s physician, and the many physicians, nurses, therapists and other members of the post-acute care spectrum. BACPAC has the potential to unite these disparate elements due to its establishment of a single site-neutral bundled payment for each distinct clinical condition and its placement of responsibility for management of that bundled payment (and attendant risk assumption) with Coordinators and their comprehensive networks of medical professionals. Free from the artificial barriers that today impede collaboration and connectedness, this model would foster collaborative management of patients within these networks throughout the 90 days following discharge. As indicated by demonstration programs now underway, such a structure can have a transformative effect on patient care and outcomes as well as operational and program efficiency. And as MedPAC has noted, “Bundled payments ... encourage providers to coordinate care to focus on managing patient outcomes and controlling costs.”²

Second among the features I would like to address is innovation. Today, a concerning gulf separates technological advances and their integration into at-home healthcare. Put another way, we are experiencing a real renaissance in the development of technological innovations that can improve patient care, outcomes and safety. As I wrote in the *New England Journal of Medicine*, an example of these innovations is the ability of physicians to “arrive at patients’ homes with a new version of the black bag that includes a mobile x-ray machine and a device that can

² http://www.medpac.gov/documents/20130614_WandM_Testimony_PAC.pdf, p 8.

² “Why Health Care is Going Home” by Steven J. Landers, MD, MPH. *New England Journal of Medicine*. October 21, 2010.

perform more than 20 laboratory tests at the point of care.”² And yet, antiquated Medicare regulations and payment rules compromise the ability of providers to utilize technologies.

Unfortunately, the Medicare program neither provides support for nor takes into account the cost of such technologies in the home setting. In fact, Medicare does not allow telehealth to be used as a substitute for covered services, provides no funding for telehealth in the home setting, and prohibits home health agencies from even including telehealth expenses in their cost report. As a result, thousands of small home health providers that do not have the resources to undertake efforts similar to ours are unable to make them available to the many seniors they serve. This means, therefore, that the potential for at-home technology is being realized today to a far smaller degree than is possible and optimal.

The BACPAC model can help rectify this problem. By authorizing the use of funds for innovations that can improve outcomes and reduce cost – such as telehealth technologies – BACPAC would bridge the gap that exists today. Further, by placing risk and the potential for gain-sharing with Coordinators and their contracted networks of providers, BACPAC creates a powerful incentive to invest in technological advances precisely because they can do a great deal to reduce cost. As a result, we view this as very positive for patients, providers and, by extension, the fiscal sustainability of the Medicare program as a whole.

Last but absolutely not least, I wish to address the matter of patient choice. As stated previously, home healthcare professionals are dedicated to delivering compassionate, quality medical treatment to seniors so they may stay with their families and in their community. We believe this is vital because we know that it’s what seniors want. As AARP has consistently documented, more than 9-in-10 American seniors wish to age in the comfort, safety and dignity of their home – not in an institutional setting. As a result, we believe that seniors’ choices must not only be preserved but strengthened in any reform that Congress may contemplate.

In our view, the BACPAC model adheres to this objective. As proposed, this legislation ensures that seniors and their families would be able to exercise the freedom of choice. Specifically, patients would have the freedom to

choose their coordinator and, thus, their network of providers. In addition, patients would also have the freedom to choose from among the providers in their selected coordinator's network. Further, the BACPAC model would actually expand the options available to seniors by reducing some of the unnecessary barriers – like the three-day stay and the homebound requirement. As a result, a patient who, for example, is not homebound but would like to receive medical treatment at home would be able to do so – today, they cannot. We believe this thoughtful approach to post-acute care reform will enable patients to receive the medical treatment they need in the most appropriate setting that they are comfortable in.

Before closing, I would also like to take this opportunity to commend the Committee for its work on related policy priorities. In particular, I would like to thank you for the focus being given to payment reform that would replace the indiscriminate harm being imposed by across-the-board rebasing cut with value-based purchasing that achieves savings via reduced rehospitalizations. Rebasing, as implemented by the Department of Health and Human Services, threatens to undermine the very home healthcare delivery system on which post-acute care reform will depend. Confronted with 3.5 percent annual cuts in 2014, 2015, 2016 and 2017, many providers are being forced to make a decision being closure, consolidation or sale – each of which threatens to limit access to the high-quality, cost-effective home healthcare services that seniors need and prefer. As a result, the focus being given to value-based purchasing as an alternative source of savings is not only superior public policy – it is giving many in my community a reason for hope in an extraordinarily difficult time.

Similarly, your continued focus on program integrity reform is worth special mention. The Partnership has long asserted that change is needed not just to recoup funds that are paid to what we call the “fraudulent fringe” but to prevent the payment of aberrant claims in the first place. To help achieve this outcome, the Partnership developed a tough package of reforms known as the *Skilled Home Healthcare Integrity and Program Savings* (SHHIPS) Act. We are very grateful for the consideration being given its provisions and are hopeful that some if not all of it may be incorporated into future legislation so that the integrity of the program on which our senior citizens depend can be fully assured.

In closing, I would like to thank you again for convening this hearing and the privilege of participating in it.

America's seniors deserve a Medicare program that provides high-quality preventive, therapeutic, rehabilitative and palliative care, and they want Medicare to be a program that will not burden their children and grandchildren with unsustainable costs.

These outcomes need not be mutually exclusive – we *can* have a high-quality *and* cost-effective Medicare program, but achieving both outcomes will require thoughtful and transformative reform. I applaud you for tackling the difficult challenge of crafting such reform. I also wish to express our appreciation and respect to Congressman David McKinley and his staff for their extraordinary work on this complex and important issue. Speaking not solely for myself or the Partnership but the home health community as a whole, I wish to assure you we stand ready to serve as a resource in your important work to Keep the Promise for America's seniors.

Thank you.

**House Committee on Energy & Commerce – Subcommittee on Health
“Keeping the Promise: Site of Service Medicare Payment Reforms”**

Wednesday, May 21, 2014 – 2123 Rayburn House Office Building

**Testimony of Dr. Steven Landers, MD, MPH
President & CEO, VNA Health Group**

Summary

Home Healthcare: Essential to America's Most Vulnerable Seniors

- Today, more than 1 million physicians, nurses, therapists and other caregivers are delivering complex medical services in the homes of the most vulnerable seniors in Medicare.
- The population we serve is documented as being older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined. Examples:
 - Stroke survivor relearning how to walk, talk and eat again.
 - Seniors and disabled Americans with MS, Alzheimer's and complex chronic conditions.
- HH professionals are a ray of light in their lives, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay in their homes and communities.

Home Healthcare: Also Essential to America's Taxpayers and Sustainability of the Medicare Program

- America is aging – 10,000 Boomers entering Medicare every day; 70 million in just 15 years.
- HH is key to helping them remain independent, in the dignity of their homes and communities.
- Our priority is to help seniors stay healthy at home, avoiding costly institutionalization.
- It's not just that there's no place like home – there's also no place less expensive than home.

Home Healthcare: A Vital Tool that Can Do Even More

- Despite the value we already provide and the difference we are making, we can do even more.
- Today, we are burdened by challenges and obstacles to efficiency and even better outcomes:
 - A payment system that is so complex it borders on nonsensical.
 - Program integrity issues, esp. in certain locations with aberrant utilization patterns.
 - The requirement that a senior must be homebound to receive medical care at home.
 - Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home.
 - Siloed payment system that creates bureaucratic obstacles to quality and efficiency.
- It's for these reasons that we are excited about the reforms that you are considering.

Reforms Now Under Consideration Offer Tremendous Promise for Improvement

- BACPAC model offers the potential to address these challenges in a significant way.
 - Breaks down the barriers that today impairs quality and imposes inefficiency.
 - Fosters care coordination across today's siloes and among multiple providers.
 - Enables mobile and homebound seniors alike to remain where they want to be – home.
 - Permits investment in technologies and innovations that will lead to truly connected care.
 - Achieves tens of billions in savings that can be utilized for much-needed SGR reform.
- We also applaud the work being done on other policy priorities, including:
 - Payment reform that would replace the indiscriminate harm being imposed by rebasing with value-based purchasing that achieves savings via reduced rehospitalizations; and
 - Program integrity reform that would stop fraud by preventing payment for aberrant claims.

In closing, Home Health stands ready to help as you embark on this critically important journey, and we look forward to joining you in 'Keeping the Promise' for America's seniors.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Thomas, 5 minutes for an opening statement.

STATEMENT OF PETER W. THOMAS

Mr. THOMAS. Thank you, Chairman Pitts, Congressman Green, and members of the subcommittee. Today I speak on behalf of the consumer-led coalition called the Coalition to Preserve Rehabilitation, or the CPR Coalition. It is about 30 rehabilitation and disability organizations, and it is run by a steering committee of the Center for Medicare Advocacy, the Brain Injury Association of America, the United Spinal Association, the National Multiple Sclerosis Association and the Christopher and Dana Reeve Foundation.

My testimony today focuses on post-acute care and the importance of preserving access to rehabilitation, timely, intensive and coordinated rehabilitation care, in the context of site-neutral payment proposals and bundling proposals.

First, I am worried about the importance of rehabilitation. The Coalition believes that rehabilitation is truly the lynchpin to improving health, function and independence of Medicare beneficiaries after an illness or an injury, a disability or a chronic condition. But these settings are not all the same, and in fact, the outcomes in these different settings are quite different, and I am happy to say that we are beginning to get new data that actually demonstrates this rather than just the intuitive sense that that is the case.

Just a quick personal word. Like many Americans, I have personal experience with rehabilitation. When I was 10 years old, I spent about 2½ months in a rehabilitation hospital, Craig Rehab Hospital in Denver, Colorado, following a car accident where I lost my legs below the knees, and proceeded to have a goal of walking into my fifth-grade class, which I did, and since then have used 13 different sets of artificial limbs over the past 40 years and have had a real front-row seat in what a good rehabilitation program and what good prosthetic care really means. All Medicare beneficiaries should have the same access that I did to that care.

Under Medicare PAC reform proposals, both site neutrality and bundling, all Medicare patients should have access to the right level of intensity coordination of rehabilitation in the right setting and at the right time and on a timely basis, and of course, that is easier said than done. We believe that any legislative changes to the post-acute care environment on these issues should not have the effect of restricting access to rehabilitation care and should avoid proposals that will lead to a reduction in Medicare rehab benefits or that erect policy barriers that will affect beneficiaries by essentially channeling them into settings of care that are less than what they need in terms of their individual or medical rehab benefits.

In terms of the SNF/INF site-neutral payment proposal that has been proposed in the last few budgets from the President as well as MedPAC, the Coalition opposes this proposal. We believe this is little more than an outright financial disincentive for inpatient rehab hospitals and unit to accept certain beneficiaries based solely on the patient's diagnosis and not based on their individual needs and rehabilitation and functional requirements.

And so while that is the case, we do not necessarily oppose bundling. In fact, recognize the different silos of care that often lead to inefficient care in the post-acute care environment and we favor well-developed bundling proposals that are based on sound evidence and are linked to quality measures and to risk-adjusted payments so that those savings are not achieved by essentially stinting on patient care. And with due respect to some of the things that I have heard this morning, we do believe that further study is needed in this area. This is a very complex area and it impacts very vulnerable Medicare beneficiaries.

In terms of the Bundling and Coordination Post-Acute Care Act of 2014, we believe that this is a model—bundling is a model again that we do not oppose—but we think that especially to protect vulnerable beneficiaries, there needs to be some improvements, and we will just quickly tick off a few of those. Number one, we have great concerns about the bundle being held by an acute care hospital or an insurance company. We believe that PAC providers, people that are in the post-acute setting who understand rehabilitation and know what the patients' needs and what they will need in terms of services should be the bundle holder in those instances. There is a concept known as the continuing care hospital pilot, which is mandated by law that CMS implemented and inexplicably CMS has not yet moved forward with that pilot. We encourage them to do so. A rehabilitation physician should be directing the care in a bundled payment system.

Device exemptions should apply. You should not have prosthetics or orthotics, durable medical equipment that are of a customized nature included in the bundle because we have got evidence based on the SNF PPS many years ago that those kinds of devices are simply not provided to beneficiaries under a bundled payment system. They are either delayed or they are denied completely. And there are certain vulnerable patient populations such as traumatic brain injury, spinal cord injury and other conditions that we do not recommend bundling, at least in the initial phases of implementation.

Risk adjustment and quality measures are obviously the most important to make sure that people are not underserved under bundled systems, and the rest of the detail on that is in my testimony. Thank you.

[The prepared statement of Mr. Thomas follows:]



**WRITTEN TESTIMONY OF PETER W. THOMAS, J.D.
 COALITION TO PRESERVE REHABILITATION
 “KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS”
 HOUSE ENERGY & COMMERCE HEALTH SUBCOMMITTEE**

On behalf of the Coalition to Preserve Rehabilitation, a consumer-led coalition of 30 rehabilitation and disability organizations, my testimony will focus on the post-acute care (“PAC”) site-neutral payment proposal and broader PAC bundling reforms. CPR believes that rehabilitation is the linchpin to improving the health, function, and independence of Medicare beneficiaries and, as such, is a cost-effective service. All settings of PAC services play an important role in the treatment of Medicare beneficiaries after an injury, illness, disability, or chronic condition. But these settings are not the same in terms of patient outcomes and it is critical to preserve access to rehabilitation at varying levels of intensity and coordination.

All Medicare PAC reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in PAC settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries’ individual medical and rehabilitation needs, simply to save funds.

CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients’ diagnoses, not based on their individual medical and functional needs. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Our testimony details a number of specific suggestions to improve the Bundling and Coordinating Post-Acute Care (“BACPAC”) Act of 2014 in a manner that protects some of the most vulnerable Medicare beneficiaries under a bundled PAC payment system.

CPR supports the collection of uniform data across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. We support existing bipartisan efforts to develop a uniform quality assessment instrument to measure functional and quality of life outcomes across PAC settings. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries.



WRITTEN TESTIMONY OF
PETER W. THOMAS, J.D.
ON BEHALF OF THE
COALITION TO PRESERVE REHABILITATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES
IN CONNECTION WITH ITS HEARING ON
“KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS”
MAY 21, 2014

PETER W. THOMAS, J.D.
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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to testify on behalf of the Coalition to Preserve Rehabilitation (“CPR”) on the issue of site-neutral payments under the Medicare program. I will confine my testimony to post-acute care (“PAC”) services. My name is Peter Thomas, and I help coordinate the CPR, which is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with disabilities, injuries, or chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the National Multiple Sclerosis Society, the Center for Medicare Advocacy, the Brain Injury Association of America, United Spinal Association, and the Christopher & Dana Reeve Foundation.

Like many Americans who have sustained a serious injury or illness, I know firsthand the value of rehabilitation. When I was ten years old, I was involved in a car accident and lost my legs below the knees. I spent two and half months in Craig Rehabilitation Hospital in Denver, Colorado and returned home walking on two artificial limbs. Since then, I have undergone additional surgeries, outpatient rehabilitation, and have used thirteen sets of prosthetic limbs over the past forty years. As a result of quality rehabilitation and good prosthetic care, I was able to become an attorney and advocate on behalf of people with disabilities. I would hope that every Medicare beneficiary, indeed all Americans, have the same access that I did to quality rehabilitative care when they encounter an injury, illness, disability, or chronic condition.

Long term acute care hospitals (“LTACH”), inpatient rehabilitation hospitals and units (“IRFs”), skilled nursing facilities (“SNFs”), and home health care agencies all play an important role



in the recovery and rehabilitation of Medicare beneficiaries.¹ The services provided in each of these settings cater to beneficiaries with a particular set of medical and functional needs which are rarely defined by primary diagnosis alone. All Medicare post-acute care reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform data needs to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries. It is one thing to maintain or improve quality outcomes while making the system more cost-efficient. It is quite another to ultimately save money in post-acute care by redesigning payment and delivery systems in a manner that does not protect against stinting on patient care and diverting beneficiaries into the least costly setting.

CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in post-acute care settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries' individual medical and rehabilitation needs, simply to save funds. In this testimony,

¹ Although these settings are commonly referenced when discussing post-acute care policy, there are other providers in the post-acute care continuum that are critical to a well-functioning system. For instance outpatient therapy, hospice providers, durable medical equipment, prosthetics, orthotics, and supplies all contribute to the Medicare-covered set of post-acute care services. In addition, there are other specialty rehabilitation providers (whether or not Medicare covers these services) that focus on specific conditions, such as residential/transitional treatment programs for people with moderate to severe acquired brain injuries.



I will discuss rehabilitation and the Medicare beneficiary, and our specific views on “site-neutrality” and bundling proposals under the subcommittee’s consideration.

Rehabilitation and the Medicare Beneficiary

Millions of individuals with injuries, illnesses, disabilities, and chronic conditions rely on the Medicare program for access to the rehabilitation services they need to improve their health, functional ability, 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 approximately 21.4 million individuals, had at least two chronic conditions in 2010.² There are over eight million Medicare beneficiaries under the age of sixty-five who qualify for the program based on their disability status. Many people or beneficiaries with all kinds of injuries and illnesses avail themselves of both inpatient hospital and outpatient rehabilitation services at some point in their lives. For all Medicare beneficiaries, the Medicare rehabilitation benefit is a lifeline to improved health and functional status, and enhanced quality of life. And yet, growth in Medicare spending has been extremely low over the past three years: approximately 1.9 percent annually on average.

While spending has grown significantly in some post-acute settings over the past decade, Medicare spent the same amount on inpatient hospital rehabilitation in 2005 as it did in 2011, with a modest uptick in spending in more recent years, according to the CMS Office of the Actuary.³ Timely, intensive, and coordinated rehabilitation provided in a rehabilitation hospital or unit decreases unnecessary long term dependency costs to the federal government. It also returns beneficiaries to their homes and communities, decreases the need to shift costs onto the states by relying on Medicaid

² *CMS Chartbook 2012: Chronic Conditions Among Medicare Beneficiaries*, CMS, 6 (2012), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>.

³ CMS Office of the Actuary as cited by Mark E. Miller, Ph.D., Medicare Payment Advisory Commission testimony on Medicare Post-Acute Care Reforms, June 14, 2013.



as the payer of last resort for long term nursing home care that might have been averted with early, intensive and coordinated rehabilitation. This level of care is also the linchpin to reduction of costly and unnecessary hospital readmissions for beneficiaries with a wide range of debilitating conditions.

Site-Neutral Payment Proposal

CPR is grateful that Congress, in its most recent legislation to adequately compensate physicians serving Medicare patients and extend the exceptions process to the Medicare outpatient therapy caps, chose not to adopt a major site-neutral PAC proposal that was included in the President's most recent budgets and discussed in-depth in recent MedPAC reports. CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients' diagnoses, not based on their individual medical and functional needs. Implementation of site-neutral payment for patients with hip fractures, joint replacements and other conditions such as stroke would simply eliminate access by erecting financial barriers to admit these individuals in inpatient rehabilitation hospitals and units. Admission decisions and treatment plans should not be based on arbitrary Medicare rules, but rather on the clinical needs of individual patients in terms of amount, duration, intensity, and scope of rehabilitation services.⁴ Because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater in SNFs—as opposed to rehabilitation hospitals and units—there is a real question as to the cost-effectiveness of treating these patients in SNFs, particularly when patient outcomes are difficult to compare across settings. These comparisons also fail to consider the downstream costs of less-than-optimal rehabilitation/functional status of patients, resulting in unnecessarily high dependency costs

⁴ For the same reason, CPR also opposes raising the 60 Percent Rule to 75 percent. This, too, is a rule that ultimately serves to bar the door to the inpatient hospital or unit based solely on the diagnosis of the patient rather than one's individual medical and functional needs.



and perhaps unnecessary institutionalization in nursing homes rather than return to the home and community setting. In addition, the site-neutral proposal is premised on the supposition that these types of patients are equally served and have the same outcomes in both IRF and SNF settings. Recent data suggest otherwise.

In preliminary study results released in March 2014 by Dobson | DaVanzo,⁵ Medicare data over a two-year period demonstrated that when patients are matched on demographic and clinical characteristics, rehabilitation provided in inpatient rehabilitation hospitals leads to lower mortality, fewer readmissions and emergency room visits, and more days at home—not in a PAC institutional setting—than rehabilitation provided in SNFs for the same condition. In terms of mortality, the starkest difference between the two settings involved patients with stroke, traumatic brain injury, and amputations. This study demonstrates that care provided in IRFs and SNFs is not the same and that outcomes are, in fact, significantly different as a result of the specific type of services provided in these two different settings. The study demonstrates the enduring effects of timely, intensive and coordinated rehabilitation provided in an IRF and how these services improve not only the length of beneficiaries' lives, but the quality of their lives as well. Rather than adopting this site-neutral proposal—and other more comprehensive PAC bundling proposals—Congress chose to exercise restraint and continue deliberating on this important set of policies. CPR applauds this Congressional approach solely based on the complexity of policies under consideration and the risks to patients if the reforms are not based on uniform, validated data and conceived with beneficiary protections in mind.

Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014

Congressman McKinley (R-WV) has released draft legislation to bundle post-acute care under the Medicare program. Known as the Bundling and Coordinating Post-Acute Care (“BACPAC”) Act

⁵ Assessment of Patient Outcomes of Rehabilitation Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge, Dobson, DaVanzo and Associates, Preliminary Report (March 2014).



of 2014, the bill seeks to bundle payments for Medicare post-acute care services (including SNF and extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, durable medical equipment, and outpatient prescription drugs). A number of exceptions to the bundle are proposed such as physician services, hospice care, outpatient hospital services, ambulance services, and outpatient therapies. The bundled payment could be held by any entity that demonstrates the financial capacity to direct Medicare beneficiaries' PAC care including acute care hospitals, insurance companies and PAC providers.

CPR recognizes that the current “silos” of post-acute care can be inefficient and can discourage episode-based care that is patient centered. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Unfortunately, a bundled PAC payment system that includes these critical beneficiary protections does not exist and, we expect, will take several years to develop, adequately test, and validate. This is why, with certain caveats, we support existing bipartisan efforts to develop a uniform quality assessment instrument to measure outcomes across PAC settings.⁶ Doing so is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients.

Until these and other patient protections are in place, we do not support legislating broad PAC bundling reforms that lock-in federal savings and defer to the Secretary of the U.S. Department of Health and Human Services (“HHS”) to implement a skeletal PAC bundling plan. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a

⁶ This draft legislation is known as the “IMPACT Act,” or Improving Medicare Post-Acute Care Transformation Act of 2014.



number of improvements we would like to suggest to improve the draft BACPAC Act of 2014, including the following:

1. **PAC Bundle Holder**: We have serious concerns with the proposal to permit acute care hospitals and insurance companies to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of rehabilitation to divert patients to the least costly PAC setting, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Current law requires CMS to pilot test a concept known as the Continuing Care Hospital (“CCH”),⁷ where the PAC bundle would be held by this new PAC-centered entity which would provide a combination of post-acute care services currently provided by LTACHs, IRFs, and hospital-based SNFs. Any one of these three PAC entities or a combination of them could be the bundle holder. This concept would properly place the bundle in the hands of providers who understand rehabilitation and these patients’ needs. In any event, the bundle holder MUST be accountable for the achievement of quality and outcome measures to protect against underservice.
2. **Entities Able to Assume the Risk**: Any bundle holder must be truly able to assume the risk of holding this bundled payment while providing services to a beneficiary across a 90-day episode of care. Financial solvency and related standards should be required by the legislation to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards ought to be tailored to PAC/rehabilitation providers, such as the standards of the Commission on Accreditation of Rehabilitation Facilities (“CARF”) and other appropriate accreditors.

⁷ Inexplicably, CMS has not yet pursued the mandated CCH pilot program.



3. **PAC Bundle Coordinator:** The draft BACPAC bill defines a “PAC Physician” as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the person charged with making treatment decisions under the bundled payment be a health care professional rather than a layperson, and that this physician has experience in post-acute care/rehabilitation service delivery, as this is the very expertise necessary to develop and implement PAC treatment plans.
4. **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle:** CPR believes that certain devices and related services should be exempt from the bundled PAC payment system, just as outpatient rehabilitation therapy and other services are treated under the draft bill. For instance, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period. Prosthetic limbs and orthotic braces are critical to the health and full function of people with limb loss and other disabling conditions. Custom mobility devices⁸ and Speech Generating Devices (“SGDs”) serve the individual needs of very specific patients under the Medicare program. Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

⁸ Custom mobility devices are often referred to as “Complex Rehabilitative Technology” or “CRT.” In fact, bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, “Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013,” H.R. 942 and S. 948.



This phenomenon was witnessed when Congress implemented prospective payment for SNFs in 1997 and initially included orthotics and prosthetics in the SNF bundle or Prospective Payment System (“PPS.”)⁹ As a result, most SNFs began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of orthotic and prosthetic (“O&P”) treatment. During this period, SNF patients experienced inappropriate and unreasonable delays in access to O&P care. Such delays and denials of O&P care often impede patients’ ability to independently function or, in some cases, result in life in a nursing home. In 1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,¹⁰ thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.¹¹ As a result, SNF patients once again had access to prosthetic limb care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we recommend that Congress exempt prosthetics, custom orthotics, and custom durable medical equipment from any PAC bundling legislation.

5. **Exemption of Certain Vulnerable Patients from First Phase of Bundling:** PAC bundling is a concept that is clearly untested at this time and, while CPR does not oppose the concept, we strongly believe that safeguards must be included in any PAC bundling legislation to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes,

⁹ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414–22 (1997) (codified at 42 U.S.C § 1395yy).

¹⁰ Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325–26 (1999) (codified at 42 U.S.C § 1395yy(e)).

¹¹ Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.



multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they are very important and very vulnerable subgroups that, we believe, should be exempt from the first phases of any bundled payment system. While such groups of patients could be phased-in at the patient's option as bundling develops, we believe the most vulnerable patients should only be included in PAC bundling on a mandatory basis when the bundled payment systems can demonstrate sufficient quality outcomes, risk adjusters, and patient safeguards to ensure quality care.

6. **Appropriate PAC Quality and Outcome Measures:** Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care. This is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTCH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care. For instance, before widespread PAC bundling is adopted, measures must be incorporated into the PAC system that cover the following domains:



- Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
 - Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);¹²
 - Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the “average” patient;
 - Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice; and,
 - Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.¹³
7. **Create Financial Disincentives to Divert Patients to Less Intensive Settings**: In order to protect against diversion of patients to less intensive, inappropriate PAC settings, we recommend that any PAC bundling legislation include instructions to the HHS Secretary

¹² These extended functional assessment and quality of life measures are consistent with the World Health Organization’s International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ (“AM-PAC”™).

¹³ “uSPEQ” (pronounced “You Speak”) is an example of a patient satisfaction assessment tool that measures the end users experience with their post-acute care experience. The survey can be answered by the patient, family or caregiver.



that payment penalties should be established to dissuade PAC bundle-holders from underserving patients.

Thank you for the opportunity to testify on this important issue area. The CPR Coalition is ready and willing to assist this Subcommittee as it continues to consider site-neutral payments and bundling proposals under the Medicare program.

Mr. PITTS. The Chair thanks the gentleman. Thanks to all the witnesses for their opening statements. I will begin questioning and recognize myself 5 minutes for that purpose.

Dr. COOPWOOD, in your written testimony, you suggest that the facility fees disparity between physician offices and hospital outpatient settings for cancer treatment is justified by the need to maintain “standby capacity that allow hospitals to respond to emergencies ranging from multivehicle car chases to hurricanes and terrorist attacks.” I would respectfully ask how this is relevant to the way Medicare pays for chemotherapy.

Mr. COOPWOOD. Thank you. The way the hospital system’s cost structure is built into the payment, we have to—there are many things that we have to do that private physician offices do not have to do. I am a former surgeon and ran a three-member group, and we had a very lean office in order to be able to economically make that system work, but in operating a hospital and a hospital system, the costs associated with 24-hour emergency care, the costs associated with the accreditation bodies, just to have a hospital-based clinic in order to qualify for Medicare patients, we have to be certified by Joint Commission. That puts a significant amount of burden and cost into the system that a private physician does not have to have.

So all of those things that you mentioned built into the actual cost to operate a hospital-based clinic, they are not directly tied to the chemotherapeutic administration but it is part of the infrastructure costs that this facility must bear in order to deliver that high level of care.

Mr. PITTS. Well, would you respond to this question? Is it fair that cancer patients face higher out-of-pocket costs for the same care when physician offices are bought by hospitals?

Mr. COOPWOOD. And I guess “fair” is the key word in your question. When hospitals acquire physician practices, and there are many drivers as to why that happens—it is not just to get a higher payment—there are physicians in oncology practices that are coming to hospitals to acquire them because of the economics of trying to run private practice, the economics of trying to get an electric medical record, the difficulties in having continuity of care and wanting to be part of a system. So there are many drivers as to why these practices are coming into the hospital under the hospital’s continuum. Because of that transition from a less expensive-run entity into a more expensive or higher-cost entity, there is where the increase in reimbursement comes in to help pay for that higher infrastructure.

Mr. PITTS. Well, are there any payment reforms or site-of-service reforms that you would support that might reduce payments to hospitals?

Mr. COOPWOOD. I think there are—in my testimony, we, being American Hospital Association, want to be a part of the conversation as we look at these payment proposals. I think that we don’t want to do in such a way that it jeopardizes the hospitals and puts hospitals at risk because if we do drastic measures in a way, it will put risk to those emergency services and all that because, as I described in my testimony, just changing it from a facility-

based payment to a private office payment adds \$8 million to my hospital on a \$300 million cost. I mean, that is significant.

Mr. PITTS. Dr. Landers, in your written testimony you observe that care is much cheaper to deliver in home-based than institutional settings. In long-term care, some worry that a shift to home-based care ends up being more expensive due to more claimants coming out of the woodwork. Is this also the case for post-acute care?

Mr. LANDERS. Thanks for your question, Chairman. As you correctly point out, care at home tends to be less expensive than facility-based care. For example, a month of post-acute care at home for a Medicare beneficiary is costing the program roughly \$1,200 to \$1,500 for that month versus in a subacute facility \$12,000 to \$15,000 for that same month of care, and we know from the variation that has been referenced earlier in this committee and from some of the research that has been submitted that there are many instances when the home is a clinically appropriate setting and we can get people home as an alternative to institutional care. So one of the opportunities in the bundled payment initiatives is to appropriately use home care, which is lower cost, often desired more as a substitute for unnecessary facility care, and not just clinically unnecessary. Patients and families don't want to be unnecessarily pushed into facility-based care, so I see this as an opportunity to save money, not to spend more.

Mr. PITTS. The Chair thanks the gentleman. My time is expired. The Chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Brooks, for the past few Congresses, I have teamed up with our Kentucky colleague, Congressman Ed Whitfield, in introducing legislation to fix a flaw in the Medicare reimbursement formula without impacting providers. This legislation is called the Prompt Pay Bill, H.R. 800, as you mentioned in your testimony, and would ensure that CMS no longer includes the prompt pay discount when reimbursing providers.

Dr. Brooks, as we talked today about factors that are causing patients to be shifted out of the community settings to more expensive settings, what impact do you think passage of this bill would have on helping prevent this shift in care?

Mr. BROOKS. Well, the prompt pay—thank you, Representative. I appreciate your bringing it up. It would help us a great deal. It would true up the legislative intent of the original legislation and right now we are not given that almost 2 percent on the Medicare service fee for managing chemotherapy drugs, and it would, in my opinion, metaphorically say take a lot of community practices off of life support, and if we were to pair it with the Rogers-Matsui bill and the Ellmers bill, we could restore vitality to community oncology, but prompt pay would go a long way standing on its own.

Mr. GREEN. Do you think addressing that formula flaw would benefit both patients and ultimately the taxpayers on the amount that is being reimbursed?

Mr. BROOKS. Absolutely. As I mentioned in my testimony, the most recent data suggests that the costs in the hospital outpatient department are almost triple what they are in our facilities, 189

percent in the IMS study. Certainly patients would benefit, because the copays would be so much less in that setting, and our practices tend to be located closer to a patient's home so that the travel is less and the patient's out-of-pocket costs are much less. Medicare gets no value from hospital-based outpatient cancer care. The patients get no value from hospital-based outpatient care.

Mr. GREEN. And have there been studies that show differences between hospital-based and outpatient facilities on the quality of the care or the results?

Mr. BROOKS. The care was assessed primarily for equality of the type of patient. There are no quality measures within those studies but there is no reason to think that the type of patients between the two facilities is any different whatsoever, and it is mostly just a cost and reimbursement setting issue. It benefits the patients to be in our clinics.

Mr. GREEN. Thank you.

Ms. Gage, under the current Medicare payment system, hospitals are not provided any financial incentives to refer patients to the most efficient or effective setting so that patients receive the most optimal care at the lowest cost. Whether a patient goes to a home health agency or skilled nursing facility, for example, depends more on the availability of the post-acute care setting in the local market, patient and family preferences or financial relationships between providers.

Ms. Gage, since patients access post-acute care after a stay in the hospital, how can we best encourage hospitals to help ensure patients receive care at the right setting after a hospital stay?

Ms. GAGE. Thank you for the question. Many of the—one way to address it is to keep the hospitals accountable for the post-discharge time period as is currently done with the readmissions policy in the fee-for-service program. Giving the hospitals accountability for the continuing care and the coordination with the subsequent providers is critical to forming the team that is needed to address the patient needs.

Mr. GREEN. I know we are doing some of that now because of the Affordable Care Act, so do you see any recent evidence that that is occurring?

Ms. GAGE. I do, as another hat that I wear is evaluating the bundled payment initiatives, and there is much more discussion in the hospitals that are participating in bundles to be communicating with the post-acute care setting and following the patient through that 90-day period and actually giving information around the entire caregiving team. It has led to reduced readmissions but there are two types of patients. There are the medical patients and the rehab patients, and in the rehab patients, you have fewer measures of outcomes than you have with the medical community except for functional change for those who have acute needs.

Mr. GREEN. That brings up my next question.

Mr. Thomas, there is resounding consensus that as part of any payment reform, robust, meaningful quality measures must be available. What challenges are there in measuring these quality outcomes of Medicare beneficiaries who receive these post-acute care services again in various settings?

Mr. THOMAS. Thank you very much for the question. Well, I would say first that the quality metrics across the different settings, the primary areas of post-acute care are not uniform and so it is very difficult to measure quality across different settings with different systems. I think that there is a lack of functional measures but in particular quality-of-life measures, and it is very important that after a post-acute care stay, it is not necessarily the range of motion that a person is able to achieve in their rehabilitation through their rehabilitation stay, it is whether that person can dress themselves again or whether they can play golf or whether they can go back to work if that is appropriate. It is returning to life roles, and that is—those kinds of measures, there are data sets that measure those kinds of things but that is where the consumer groups or disability groups would like to see much more emphasis on measuring those kinds of things of returning back to community life and living as independently as possible, and if you can't do that as a result of a particular post-acute care stay because you weren't set to the proper or the more intense setting of care with that set of services that you really need to meet your individual and unique needs, then you are really not getting all you can out of the Medicare program, and that would be a real shame.

Mr. GREEN. Thank you, Mr. Chairman, and we will probably have some other follow-up questions of the panel. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Ms. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel for being here today. These are issues that are very, very important to me, having been a nurse for over 20 years prior to coming to Congress, and again, also, my husband being a general surgeon and actually having had his own solo practice and now has joined a practice owned by a hospital, and I would say to that point, there are significant economic factors that play into that, especially now with the Affordable Care Act, and many of the costs that our physicians in private practice are faced with, and we understand the hospitals are also faced with many of those same situations, and I think it is important to point out and recognize that individual patient offices, small businesses are faced with many, many issues of overhead, Dr. Coopwood, you mentioned electronic medical records being one of them, great cost to individuals and practitioners, and those are definitely hurdles.

But on that, I do want to talk—Dr. Brooks, you had mentioned, and I would like to talk a little bit about my bill, H.R. 1416, addressing the sequester cuts to Medicare Part B drugs as a result, as we know, of the sequester cut. Unfortunately, now, it has been over a year since I introduced that bill, and we do have a number of cosponsors. However, it is one of those things where information has to be gathered as we move along, and unfortunately, the results are playing out. There are many community cancer settings that are closing their doors or are being bought up by hospital practices. In fact, I had mentioned this in the previous panel with Mr. Miller, that a practice in my hometown that has been a 30-year oncology practice, private practice, has now been purchased by one of the hospitals. Now those same patients, although they will

be able to receive the care in that same clinic, will be paying more money, and I do think that this is significant and something that we must draw attention to.

So I guess my question to you very simply and very plainly is, if we were to pass H.R. 1416—and again, when I talk about Medicare Part B drugs, it is not just chemotherapy drugs. We are talking about other drugs that any physician would have to be responsible for administering in the outpatient setting. Would there be a cost savings to that patient and would there be a cost savings to Medicare overall?

Mr. BROOKS. If we were to pass 1416, and right now, for those of you who are not familiar with the perverse interpretation of CMS on our Part B payments, they decreased our service fee for managing chemotherapy and oncology offices not by 2 percent as we anticipated but by 28 percent when one does all the calculations because they included the entire cost of the drug. And so our service fee was decreased by 28 percent. This has caused great hardship in the oncology communities, and even with my own U.S. Oncology Network, we have practices now in peril, and prior to sequestration, really those practices were fine. So this additional blow on top of the lack of prompt pay relief and the lack of site neutrality payments—I mean, CMS decreased our reimbursement for chemotherapy infusion again this year—those triple burdens are causing practices even in our very robust, efficient network to be financially imperiled, and if we got 1416 passed, we got relief from that, that would put us back just like Representative Green's question, it would take us off of life support. Right now, we are impoverished and barely paying the light bills.

Mrs. ELLMERS. Thank you, Dr. Brooks.

And Dr. Landers, I do have a question for you. I am a huge proponent of home care services. I think we are helping our patients, especially our Medicare patients, our most vulnerable, to stay out of the hospital setting where they can be at home receiving care. One of the other issues, as we know, and I am sure you are aware as well, and I just want to get your verification on this. We are talking about a patient population of Medicare patients who are largely women and we are also talking about an employee population that is by and large women as well. You know, we are faced with this question here in Washington all the time: how can we empower women and what is the true war on women. How do you feel about that situation?

Mr. LANDERS. Congresswoman, thank you for the question. In my experience, one of the best things about my work has been with many nurses and patients and family caregivers, quite frankly in home care most of them have been women, and if you look at the Affordable Care Act re-basing cuts that are sort of just across-the-board, non-risk adjusted, non-outcomes-based cuts, they are hurting women disproportionately because that is where—that is who is involved with home care by and large, our employees, our nurses, our therapists, our social workers, our aides are disproportionately women. The patients tend to be women and also we can't forget family caregivers. Although some of us men chip in every once in a while, the women nationally are bearing the brunt of the family caregiving responsibilities and home care is their support

and their lifeline. So I am glad that you brought that up, and I think it is important that we are focused on payment reform and innovation based on value rather than these across-the-board disproportionate cuts on things that hurt a lot of people including a lot of women.

Mrs. ELLMERS. Thank you, Dr. Landers, and thank you, Mr. Chairman, for indulging me and letting me go over a little bit.

Mr. PITTS. That is all right. Thank you. The Chair thanks the gentlelady.

We are voting. We have got 12 minutes left in the vote. We will go to Mr. Rogers, 5 minutes for questions.

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

Mr. Brooks, can you tell me in your experience as a community oncologist what this shift that we talked about earlier of the closure of so many, 241, I think, practices around the country, what impact does that have on a patient that is in one of those 241 closed facilities?

Mr. BROOKS. Thank you for the question. I have had the opportunity to talk to some of my friends who have been acquired by the hospital, and I have been curious about some of the hospital assertions that licensing requirements and other things are more onerous under that situation. I have not been able to discern any additional licensing requirements that were required for these offices that were taken over, but one of my friends in another State, I talked to him recently, and when he transitioned his patients who were on chemotherapy from his bills to the hospital bills, he had several patients come in with their bills and say what is this, because the bills were over 100 percent more than what he had charged them from his own thing, and the door had changed names but the nurse was the same, the doctor was the same, the office was the same, and the patients were confronting him and he had substantial angst, but in his defense, their practice was in peril financially. They were not doing well, and they could have hung on a while longer but they were on an intolerable course based on, in his case, mostly sequestration.

So there have been serious displacements among my colleagues and they are not happy to go to the hospital. They would prefer to be independent but in many cases want to continue to take care of their cancer patients and that was their only option.

Mr. ROGERS. And what about those that have been closed? I mean, we talked a lot of numbers. I could talk to you all day long about the cost disparities or not, the payment disparities or not, but a patient is in that mix and in that number somewhere. So my center closes. What happens? If you are an average patient there, you are in the middle of some radiation treatment that is not an easy process to go through, talk about the patient, Doctor, if you would.

Mr. BROOKS. Oh, the patients are at the center of our concern here, and if our centers in rural Texas close, we are the only providers. Hospitals are always talking about being the only provider but we are the only provider for cancer care in most of rural Texas, and if our center, say, in Paris, Texas, where we are 70 percent Government pay, if that center were to be deemed by our organization to be no longer financially viable and we had to close that,

those patients would have to drive more than 100 miles each way for a radiation center.

Mr. ROGERS. And what does that mean? If I am a patient undergoing treatment, what does that 100 miles mean to me?

Mr. BROOKS. Well, Representative Rogers, if you are frail enough, you can't do it. You can't continue 100-mile commute every day for five weeks, and it is an issue that comes up for us all the time. Frail, elderly patients cannot make long commutes. They are not able to. And they choose to discontinue treatment and not get adequate care.

Mr. ROGERS. And I have heard examples and I am sure you have heard examples of people who are choosing not to continue care or treatment because of the distance to travel.

Mr. BROOKS. Yes, sir.

Mr. ROGERS. Well, that is one way to save money, I guess.

Mr. BROOKS. Yes, sir, it is a perverse way to save money, but it is true that patients discontinue therapy because of travel burdens, particularly in States that are spread out like Texas.

Mr. ROGERS. My frustration with this is exactly what you said, so one day the shade goes down and it is whatever the rate is, the next day it opens up under this new contract because a hospital-affiliated center now and the price goes up, and I think the number we heard was roughly 20 percent on average across all of the specialties. What is the difference in care that that person gets from the day that the shade goes down until the day the shade goes up? What is the difference in care?

Mr. BROOKS. There is no measurable added value for those patients, and there is no measurable added benefit to Medicare for transferring the care.

Mr. ROGERS. Are there more regulations they have to follow?

Mr. BROOKS. I have actually—the hospitals assert that. I have looked into that, and I have asked my friends who have been acquired by the hospital and have not been able to find any additional licensure requirements or other regulatory burdens that they had to bear after hospital acquisition. I sought that information and was not able to find any.

Mr. ROGERS. Again, Mr. Chairman, I think we would all be remiss in our duties if we stand by and allow one more cancer patient not to be able to make travel, select not to get treatment or their costs go up so prohibitively they can't continue treatment. Shame on all of us if we can't pull this together pretty soon so that we don't lose any more of these centers. I think it is awful important we deal with this issue soon. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. There is 6 minutes left to vote on the floor. Dr. Burgess, you are recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman, and again, I want to thank our panel. I appreciate you being with us today and your forbearance through what has been a long morning.

Dr. Brooks, as you were answering Mr. Rogers' question, I think he asked specifically about someone who was receiving radiation therapy, but a chemotherapy patient then has that 100-, 120-mile drive home, I can't quite do the calculation on how many sublingual Zofran may have to be consumed on that drive but you are

adding a significant burden to the clinical course of that patient, are you not?

Mr. BROOKS. Yes. Travel is a burden when you are ill. I mean, any of us who have just had the flu and tried to drive to your local doctor's office understand how crummy you feel in a reasonable commute. But in very long commutes for people that are chronically and acutely ill, it is intolerable, and people do select to discontinue care for that reason.

Mr. BURGESS. I am old enough to remember when your partners came to our community hospital, and we were grateful for that, to have the services for our patients, but I also remember not being able to electively hospitalize a patient on a Tuesday because that is the day your partners filled the hospital up with their chemotherapy patients, so it was also a great day when they opened their own center and now the chemotherapy was administered as an outpatient. So are we in fact driving back the other way? Is hospital bed availability going to become an issue because of the occupancy of those beds with chemotherapy patients?

Mr. BROOKS. Well, it is a little different these days. We don't actually put people in inpatient beds like we did—I actually didn't know you were that old. But in my youth as an oncologist, we did in fact hospitalize patients, put them in hospital beds. Nowadays, most hospitals have outpatient treatment departments that look quite similar to our physician offices, and they do not occupy inpatient beds in most cases. So that is not a concern per se.

But the migration, like Mark Miller said earlier, from the lower cost, more efficient to the higher cost, less efficient because of the economic incentive, and that is what we are looking at here.

Mr. BURGESS. Yes, and I actually tried to encourage him to be a little bit more vocal about that, and I wasn't able to draw it out of him, so I appreciate your articulating that concept because I think it is important.

I used to be a student of medical irony but now I have kind of branched out. I just cannot tell you the frustration of dealing with the Centers for Medicare and Medicare Services trying to get them to calculate a correct arithmetic equation of the 2 percent reduction in the sequester of ASP Plus 6, and this was the subject of a letter. We had a lot of people that signed on. To their credit, they wrote me back but they wrote me back to me indicating that they didn't understand how to do simple arithmetic. ASP Plus 6, for people who don't understand what that is, that means you take the average sales price of, in this case, a drug, and you add 6 percent, which arguably should cover the cost of storage, administration, your staff's time, the IV tubing, all of the things that are connected with administering that drug. I recognize that the plus 6 doesn't really cover that, but still, in theory, the plus 6 should cover that.

But it makes no sense if you are going to apply an across-the-board reduction with the sequester of 2 percent. You would never begin with the ASP part of that equation. The ASP part of that equation is a fixed cost. That is a direct cost. That is like saying well, we are going to reduce—someone is going to come in and reduce your light bill by 2 percent because Medicare is cutting you 2 percent. They are not going to do that. Your electricity charge for keeping the drug refrigerated, your carrying charge is all the same.

It has not been impacted. No one has cut you a break because Medicare is reducing your reimbursement.

So I continue to be frustrated with that. I continue to try to educate our good friends over at the agency. So far, I have not been successful, but like you, I fear that the consequence of this error in calculation is going to be a big driver. Again, you so well articulated what the actual reduction means to your clinic and your office and how hard it will be to keep your doors open.

Let me just ask one last thing before we finish up and I have to go vote. The issue of EMTALA came up, and Dr. Coopwood, I think you referenced that, that this is of course something that the hospital bears, but doctors bear it too. I mean, EMTALA applies to both providers that are both physicians and hospitals. So the question on the EMTALA mandate actually affects both physicians and hospitals. Is that not correct?

Mr. COOPWOOD. I am really just aware of the responsibility of a hospital's role in EMTALA. Someone shows up on their perimeter property, they have a responsibility to treat them and at the minimum stabilize them. I am not sure if that extension goes into the physician's office practice because they are not obligated to see everyone who presents to them as a hospital is obligated to see everyone in emergency situations.

Mr. BURGESS. Let me elaborate on that just a little bit, because as a member of the hospital staff of your hospital, if your emergency room doctor calls me because of a woman in labor, for example, I got to show up. I have got to show up within 30 minutes or a \$50,000 fine comes my way. So I would just argue that it does affect the doctors as well as the hospitals. It might not affect the bottom line in our office practice, but as far as the taking of our professional services, it still occurs under EMTALA as it does for you.

Mr. COOPWOOD. Absolutely.

Mr. BURGESS. Mr. Chairman, I know we have a vote on.

I want to thank our panel again. It has been very informative. I have got some questions I am going to submit for the record. Thank you for being here, and I will yield back.

Mr. PITTS. The Chair thanks the gentleman.

There is no time left on the clock for voting, so I urge members to get over to vote. We still have some 250 people who haven't voted.

Thank you for your responses, for the questions. Some additional questions we will send to you in writing. We ask that you please respond promptly. I remind members that they have 10 business days to submit questions for the record, and I ask the witnesses to please respond promptly. Members should submit their questions by the close of business on Wednesday, June 4th.

A very good hearing. Thank you so much for sharing your expertise with us. Without objection, the subcommittee hearing is adjourned.

[Whereupon, at 12:48 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Chairman Fred Upton Opening Statement
“Keeping the Promise: Site-of-Service Medicare Payment Reforms”
May 21, 2014

Thank you Mr. Chairman. The Medicare program is an important lifeline for millions of seniors and disabled Americans, but its deteriorating fiscal state is putting that lifeline at risk. Our committee remains focused on steps Congress can take to preserve the promise of Medicare for those who rely on the program, both today and for generations to come.

The Medicare Payment Advisory Commission, or MedPAC, has put forward a number of proposals that it believes would improve the effectiveness of Medicare by equalizing payments for the same service regardless of where it is delivered. These could potentially reduce out-of-pocket costs for seniors, while saving billions for taxpayers, by making sure care is delivered by the institutions that do so best.

In its March 2014 report, MedPAC identified Post-Acute Care – or those rehabilitative services provided to patients once they leave an inpatient hospital setting – as one area ripe for reform. They suggested that aligning the currently uncoordinated reimbursement systems would allow us to compare, assess, and reward where care is best delivered. Such proposals have found their way into legislation and continue to be raised as potential offsets for SGR reform legislation, among others.

Given the attention and respect that MedPAC proposals receive from Congress, I want to commend the Chairman for holding this hearing today. Post-Acute Care is an important area of jurisdiction for this committee, and today’s

hearing will allow members the opportunity to hear from proponents and opponents of such policies as we continue the important discussion of what steps Congress needs to take to keep the promise of Medicare for seniors.

I also want to commend committee members Mike Rogers and David McKinley for their respective bills in this effort. Today we will consider Congressman Rogers' proposal that would reimburse cancer care services equally regardless of whether they are provided in a hospital or physician's office, and Congressman McKinley's bill to combine the various Post-Acute Care payments into one reimbursement payment. These legislative initiatives are worthy of our serious consideration, and I look forward to hearing thoughts from all sides on them today.

With that, I yield the remainder of my time to _____.

**Statement of Rep. Henry A. Waxman
Committee on Energy and Commerce
Subcommittee on Health
Hearing on “Keeping the Promise: Site of Service Medicare Payment Reforms”
May 21, 2014**

Mr. Chairman, I am glad to see the committee taking interest in issues of post-acute care reform. There is much exciting work going on in this area but also much more that needs to be done. Our committee clearly has a role to play in advancing positive, beneficiary-focused reforms related to post acute care for Medicare beneficiaries.

We have a Medicare system right now with misaligned incentives, inaccurately priced payments, and little information on the quality or outcomes of beneficiaries served by post acute providers like skilled nursing facilities, home health agencies, or rehabilitation facilities. And, Medicare spending in this area is increasing rapidly. It was 62 billion dollars in 2012.

The Affordable Care Act recognized these issues and set the stage for post acute care reform, by putting in place a number of stepping stones for PAC reform. Medicare is testing a number of payment system reforms that will help improve care and outcomes in this area.

We know there is a lot of variation in the quality, outcomes, and costs of PAC around the country. The need for PAC is not well defined. We also know there are more efficiencies and improvements to payment accuracy that must be done – and some of those can be done now. Before we can envision a wholesale redesign of the payment system, however, we need more data. We do not have any common and comparable data across providers like skilled nursing facilities, home health agencies, and others, to determine which patients fare best in which settings, or even what appropriate levels of care are for patients of varying acuity.

I commend the Ways and Means and Finance Committees for putting out draft legislation on that issue to get the discussion started. I also commend MedPAC for diligently reminding Congress of the misaligned incentives and need for action. Their work and recommendations should be a useful guide for our efforts.

I hope that we can continue the bipartisan tone in this area and work to develop some exciting solutions in the near future.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
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House of Representatives
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June 11, 2014

Dr. Mark E. Miller
Executive Director
Medicare Payment Advisory Commission
425 Eye Street, N.W., Suite 701
Washington, D.C. 20001

Dear Dr. Miller:

Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

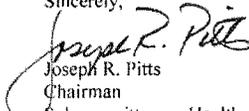
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

QUESTIONS FOR THE RECORD
COMMITTEE ON ENERGY AND COMMERCE -- HEALTH SUBCOMMITTEE
MAY 21, 2014

TESTIMONY BY MARK MILLER, Ph.D.
EXECUTIVE DIRECTOR,
MEDICARE PAYMENT ADVISORY COMMISSION

The Honorable Joseph R. Pitts

1. Some have proposed that Post-Acute Care bundling reforms are premature and should not even be considered by Congress until such time as a standardized assessment tool is created and data collection is complete. Others have pointed to the fact that such perfecting of data collection could take a decade or more and even then, such an assessment will need to be refined. Do you agree with the notion that Congressional consideration of bundling should only occur after an assessment tool has been crafted and sufficient data collected or can both be done concurrently?

Answered in testimony. See transcript.

2. Medicare payments are a huge influence on the healthcare industry, often serving as a baseline for negotiations between hospitals and private insurers. Do private payers mimic Medicare site-of service reimbursement disparities? Do private insurers obtain similar discounts for care that is provided through physician offices and Ambulatory Surgery Centers? Have any private insurers adopted site-neutral payment policies similar to the recommendation that MedPAC has made to Congress?

Answered in testimony. See transcript.

3. The respected journal *Health Affairs* recently released a study, finding that hospital ownership of physician practices is associated with higher prices and spending. Would you comment on how Medicare's payment differentials impact might have spillover effects to the private sector and health system?

Answered in testimony. See transcript.

4. Payment transparency is important for us to ensure that Medicare gets value for money. A 2013 GAO study found that 91 % of hospitals receive upward payment adjustments relative to the standard Medicare fee schedule. Hospitals are also often exempt from state and federal taxes, and receive extra federal funding for uncompensated care costs. How much greater are price disparities between sites of service when these additional factors are taken into account?

It is very difficult to account for the factors cited above, given the wide variation across providers in the amount and type of tax exemptions and payment adjustments received. Non-profit hospitals and non-profit systems employing physicians are exempt from state and federal corporate taxes, but for-profit hospitals are not. Disproportionate share hospitals receive uncompensated care payments, but those serving smaller shares of poor patients do not. Physicians pay personal income taxes, but may avoid corporate state and federal income taxes by forming an S-corporation or a limited liability company. In the outpatient payment system, Medicare adjusts payments upward for all services provided in sole-community hospitals by a uniform rate, but this is offset by lower payments to all other hospitals to make the policy budget neutral. Given these complications, we do not have sufficient data to calculate price disparities that account for the factors you describe. We can say that the current difference, even prior to making these adjustments, is substantial and can distort the market for these services.

5. **Understanding CMS's impact as a payer on the shaping of our health care delivery system, I am concerned about the lack of communication and collaboration between the various payment staff at CMS. Do you believe that those with control over the various payment rules within CMS should be collaborating when putting forward payment rules that have the potential to shape the future of our health care system?**

The Commission has long been interested in moving away from fragmented, silo-based delivery systems, and has recommended payment reforms that would encourage more efficient, coordinated care focused on the needs of the patient. Such reforms include setting site-neutral payments for similar services provided in different settings and implementing a standardized assessment tool for all post-acute care settings. If the Congress were to decide to enact those recommendations into law, it would seem appropriate to have relevant CMS staff from each of the affected provider payment areas involved in the policy development to ensure that such reforms are well developed and do not have unintended consequences for the Medicare program or the broader health care delivery system.

6. **Do you think CMS should be required to provide an analysis of a rule's expected impact on other areas of the health care delivery system, including the impact on provider consolidation, as part of the analysis and transparency in their rule-making process?**

When the Commission evaluates proposed changes to Medicare's payment systems, to the extent feasible it reviews the effect of such policies on beneficiaries and providers, as well as on the delivery of health care services more broadly. However, due to data limitations, it is not always possible to estimate the impact of a proposed change on all aspects of health care delivery. If CMS were able to conduct such analysis in its rulemaking process, it could inform the Congress and other stakeholders' comments on proposed rules, but it may not be feasible in all instances.

7. **We have had a number of hearings on the state of Medicare spending on how its current trajectory threatens access for future beneficiaries. MedPAC has suggested some reforms to address those concerns, including site-neutrality and Post-Acute**

Care bundling. Would you explain how important such reforms are for the future of the Medicare program and those looking forward to retiring into the program in future years?

As you note, the Commission has recommended that Medicare make comparable payments for similar services regardless of where the services are provided. This policy concept is based on the principle that a prudent purchaser would obtain care in the lowest-cost setting where safe, high quality care is provided. In many cases, the Medicare patient benefits, since a lower Medicare payment to a provider may also mean a lower beneficiary copayment (as would be true in the case of equalizing payments for certain services between hospital outpatient departments and freestanding physician offices). In addition, lower Medicare payments help to preserve the sustainability of the Medicare trust fund into the future.

The Commission also supports ongoing testing and implementation of new payment models that promote care coordination while discouraging unnecessary utilization and excessive payments. Payment models that require providers to be accountable for an entire episode of care have the potential to reduce spending and improve care. Implementing policies that achieve the twin goals of better care and lower spending will be critical to preserving the Medicare benefit for future generations of beneficiaries.

- 8. In your report, examining potential ambulatory payment reforms, you talk about how seniors on Medicare can save money from reduced cost-sharing. Would you give me an example of that for an average senior?**

For level 2 echocardiograms (ambulatory payment classification number 269), the beneficiary's copayment is \$98.36 if it is provided in a hospital outpatient department, but only \$45.60 if it is provided in a physician's office. The copayment is 116 percent higher in OPDs than in physicians' offices. Under our recommendation, the copayment in OPDs would decline to \$45.60.

- 9. If Congress did not adopt payment reforms that provided more site-neutral payments, how can we ensure seniors have better information to understand certain care settings may cost them more?**

There are several ways to educate beneficiaries about the differences in cost sharing they may face in different settings. For services that can be provided in both physician offices and OPDs, the Congress or CMS could require physicians and other practitioners to inform their patients that it is more costly to receive care in OPDs than in freestanding offices. Medicare could also make this information available to beneficiaries through notices sent in the mail or posted on the Medicare Hospital or Physician Compare websites.

- 10. In your testimony, you raised issues related to the trend of hospitals purchasing physician practices, noting that it can increase spending by private plans and higher cost sharing. I understand that MedPAC has done some work in the past to estimate how much it costs Medicare to provide services in a hospital outpatient setting that**

could be offered in a physician office setting. Has MedPAC performed any follow-up work to examine how much provider consolidation might impact Medicare costs? How might some of MedPAC's recommendations regarding payments help minimize any potential cost increase associated with provider consolidation? Is there anything that can be done through more transparency in the claims process that could lead to further insights into the impact of provider consolidation on costs?

By provider consolidation, we assume you mean hospitals acquiring physicians' practices or ASCs. This trend has resulted in services migrating from less costly settings (e.g., freestanding physician offices) to more costly settings (e.g., hospital outpatient departments). For example, in 2012 Medicare saw a 7% drop in the volume of echocardiograms provided in the physician office setting and a 13% increase in the same services provided in hospital outpatient departments. The impact of the migration of this and other services on program and beneficiary spending is significant. We estimated that Medicare pays approximately \$2 billion more annually for services that are provided in the hospital outpatient department that could reasonably be provided in the freestanding office, and recommended that Medicare hospital outpatient department payment rates for these services be reduced. The Commission's recommendations on equal payments across settings can mitigate spending increases that result from provider consolidation, because payments for some services that have migrated to the higher cost outpatient department would be reduced.

Currently, Medicare lacks data that directly shows provider consolidation because the data on physician practices that have been purchased by hospitals and converted to provider-based status are very poor. To produce this type of data, Medicare could require providers to indicate on claims when a service is provided in an off-campus department that has provider-based status. CMS has proposed doing so in a recent notice of proposed rulemaking.

11. According to a Merritt Hawkins survey, the proportion of final year medical residents saying they would rather be employed by a hospital than work in other practice settings rose from 3% in 2001 to 32% in 2011. To what extent are Medicare practice expense payment disparities responsible for the decline in attractiveness of independent practice? How do these payment disparities compare with other factors driving the decline of independent practice?

We have identified three factors that have likely contributed to the decline in how attractive independent practice is to medical residents. These include:

- An increase in the cost of running a practice.
- A desire for a different work-life balance and more lifestyle flexibility.
- A financial benefit from being employed by a hospital over owning your own practice.

It is very difficult to disentangle how much each of these trends has contributed to residents' opinions about owning their own practice because they have occurred at the same time.

- 12. Medicare payments are a huge influence on the healthcare industry, often serving as a baseline for negotiations between hospitals and private insurers. Do private payers mimic Medicare site-of service reimbursement disparities? Do private insurers obtain similar discounts for care that is provided through physician offices and Ambulatory Surgery Centers?**

Answered in testimony. See transcript.

- 13. MedPAC's March 2014 report states that "the lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. How important is risk adjustment to any proposal that Congress puts forward on bundling in the Post-Acute Care space?"**

Risk adjustment is key to making valid comparisons across patients and providers. Without it, providers may appear to be inefficient or high cost, or to furnish lower quality of care or have worse outcomes when in fact they treat sicker patients. The lack of comparable information also undermines our ability to examine whether certain providers or settings selectively admit certain types of patients and avoid others. Comparable information will also help beneficiaries and their caregivers make accurate comparisons in selecting a setting or provider.

As Medicare moves towards value-based purchasing and broader payment reforms (including bundling), comparable information is critical to evaluating a provider's or a setting's mix of patients, costs, and outcomes. If the approach to bundling includes a target payment or benchmark, it will be important to risk adjust the provider's actual payments for the severity of the mix of patients it treats. Otherwise, a provider could be unfairly penalized or rewarded based on its mix of patients.

In addition to assisting us with risk adjustment, comparable information about patients in the different PAC settings can also enable Medicare to set payments more accurately across settings. For example, Medicare could consider narrowing the payment difference between skilled nursing facilities and inpatient rehabilitation facilities for certain conditions that are frequently treated in both settings. Setting payment rates more accurately would help when developing bundling proposals because it would provide a more precise set of input prices when determining how to pay for the entire bundle of services.

- 14. MedPAC's 2014 report states that "there is no common patient assessment instrument used across Post-Acute Care settings." It has come to my attention that various industries can have proprietary feelings about their own tool and encouraging a common tool amongst the various provider types might be difficult. Does MedPAC have any suggestions as to how we might encourage the broad**

adoption of one tool? MedPAC has cited the use of the CARE tool as evidence of the type of common assessment tool that might be used in this space. Are there lessons from the CARE demonstration that might help educate Congress when considering legislation?

Minimizing providers' administrative burden is an important factor in encouraging the adoption of common assessment items. The common assessment items could be added as a supplement to existing assessment tools for SNF, IRF and home health care, minimizing the impact of adopting common measures (it would be a new data collection tool for LTCHs as they currently have no required patient assessment instrument). Most of the existing tools would remain in place, significantly reducing the work needed to master the new items. The common items could be phased in over time, which would allow providers more time to conduct transition activities. The initial set of common assessment items should include a limited number of select items from key domains that are important for adjusting outcomes and payments for patient differences. These items should include functional status, cognitive status, and the provision of special services (such as ventilator care or intravenous drugs). CMS could retire the existing items on the required assessment tools once sufficient data had been collected to permit the use of the common assessment items for payment and quality measurement.

A number of training and support activities were conducted as part of the CARE demonstration, but we are unaware of any analysis of these efforts. The experience of the CARE demonstration suggested that providers from all settings could be trained to accurately use a common set of assessment items. Proper support is essential for ensuring that providers understand assessment requirements. CMS may want to review its past efforts to educate providers and the implementation of the existing assessment tools to identify best practices for use in implementing any new common assessment items.

- 15. In any sort of legislative push toward bundling, data collection is key. Understanding how difficult quality measurement is in the area of rehabilitation and therapy, does MedPAC have any suggestions on ways to begin data collection and measurement? Are there certain focus areas under which data collection should begin like functional status for instance?**

The Commission has recommended that the initial set of common assessment items should include functional status, cognitive status, and the provision of special services such as ventilator care or intravenous drugs. These items could be added to the existing assessment tools, and replace them as soon as practicable. These items would facilitate comparisons of resource use and quality, and support the development of a common case-mix system. Additional items could be implemented in later years, covering other areas such as the availability of a caregiver in the patient's home.

- 16. In its 2014 March report, MedPAC states "the Commission believes Medicare needs to move away from fee-for-service (FFS) payment and toward integrated payment and delivery systems to control unnecessary volume and enhance patient outcomes.**

How much unnecessary volume of inefficient care has MedPAC found exists in the Post-Acute Care space?

In the Commission's 2011 report on geographic variation in Medicare spending we reported that the variation in the use of post-acute care was greater than for other services. For example, the area at the 90th percentile had spending that was two times the spending found in the area at the 10th percentile. At the extremes, the differences are even larger. For example, home health spending in Miami-Dade county in 2008 was more than 15 times the spending in a neighboring Florida county. It is difficult to categorize how much of this care is inefficient, but the analysis suggests that significant savings could accrue if higher-spending areas could reduce their utilization. Payment models that better reward efficiency, such as ACOs or bundling of inpatient and PAC, could be a means for lowering PAC use in high spending areas. Medicare's fee-for-service payment systems reward additional volume, contributing to the wide disparity in spending among areas.

17. How might assessment, data collection, and quality measurement impact other areas of Medicare like Medicare Advantage or ACOs? Would such data collection help improve these differing models of care?

The collection of comparable information will benefit all models of care delivery – FFS, ACOs, and MA. In addition, we expect the information to have benefits for beneficiaries, providers, and the Medicare program.

Beneficiaries – whether in traditional FFS, ACOs, or MA plans – stand to benefit from this data collection because they will be able to incorporate information about quality into their decisions about where to seek care.

Comparable information would also allow ACOs and MA plans to select high-quality, efficient providers as preferred or “in-network,” and to use the information to evaluate provider performance in renewing the providers in their networks.

18. In MedPAC's March 2014 report, it states that the Commission has begun to develop outcome-based quality measures that are risk adjusted so that the efficacy of settings and services can be evaluated. How long do you believe it will take the Commission to complete its work and how important will such measures be for future reform efforts?

The Commission is considering a new approach to measuring and reporting on the quality of care within and across the three main payment models in Medicare: FFS, MA, and ACOs. This quality measurement approach would deploy a small set of population-based outcome measures (such as potentially preventable hospital admissions, potentially preventable ED visits, and patient experience measures) to assess the quality of care in each of the three payment models within a local area.

The Commission's vision is that over the next several years, Medicare would move away from publicly reporting on dozens of clinical process measures and toward reporting on a

small set of population-based outcome measures for the beneficiary populations served by FFS Medicare, ACOs, and MA plans. By focusing on meaningful quality measures, Medicare could improve value for the beneficiary and the taxpayer and reduce administrative burden on providers.

The Honorable Michael C. Burgess

1. **Outpatient hospital departments and ambulatory surgical centers have similar requirements to participate in the Medicare program and to be licensed at the state level, and both provide high quality care for similar services, yet the reimbursement rates and fee schedule for each site are widely different. A large focus of the hearing was on the need for payment equity, with the general assumption that hospital reimbursement rates should be lowered to reflect those provided to other outpatient settings. What would the cost and benefit be for achieving equity through raising the reimbursement rate in certain outpatient settings such as ambulatory surgery centers while lowering the reimbursement rate in others? What impact would this have on hospital consolidation or expanded use of other outpatient settings? How would this affect patient access to care and costs overall?**

The Commission has specifically examined the differences in payment rates between ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs). In the Commission's June 2013 Report to the Congress, we identified 12 sets of services that met our criteria for equal payment across OPDs and ASCs. Payment rates for ASCs are less than those for OPDs; the 2013 ASC conversion factor was approximately 60 percent of the outpatient conversion factor. We estimated that reducing OPD payment rates to the ASC level for these 12 APCs would reduce program spending and beneficiary cost sharing by a total of about \$590 million in one year.

We did not examine the effects of raising ASC payment rates while lowering HOPD rates. Depending on how the policy is structured, hospitals' incentives to consolidate or acquire other providers would decline, and they would likely reduce their volume, which could reduce program spending in that sector. Existing ASCs might expand and new ASCs could enter, which might increase volume and program spending in the ASC sector. Therefore, the net effect on overall volume and program spending is ambiguous. Furthermore, beneficiaries are currently receiving these services in ASCs, which suggests that ASC payment rates are high enough to assure access to these services. Therefore, setting site neutral rates higher than current ASC rates would result in Medicare payment rates that are higher than needed to protect access to care.

In all of our analyses on this issue, we emphasize that payment rates should be higher in OPDs for some (but not all) services when patient needs differ between hospitals and freestanding offices. For some services and for some patients, the standby emergency capacity offered by hospitals is necessary to assure patients' safety. Therefore, making payment rates for all services equal across ambulatory sectors has the risk of compromising patients' safety and should be avoided.

2. **The Medicare Program currently restricts certain kidney transplant recipients to 36 months of anti-rejection drugs. These Medicare beneficiaries require anti-injection drugs for the remainder of their lives. After the 36 month ends, these patients return to the significantly more expensive dialysis treatment. What are the cost implications for such a policy? Would expanding use of these drugs lower long-term costs for these patients who may need dialysis treatment and/or another kidney once coverage for these medications expires?**

The 1972 amendments to the Social Security Act extended Medicare benefits to people with end-stage renal disease (ESRD), including those under age 65. The Omnibus Budget and Reconciliation Act of 1986 provided coverage of immunosuppressive drugs furnished within one year of an individual's Medicare-covered transplant. Under the Omnibus Budget Reconciliation Act of 1993, immunosuppressive coverage was gradually extended from 12 months following a covered transplant to 36 months. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) effectively eliminated the 36-month time limitation for immunosuppressive coverage for Medicare beneficiaries age 65 years and older and the disabled. The Congressional Budget Office estimated that the cost of this BIPA provision was \$0.1 billion in 2001 and \$1.4 billion over the 2001-2010 period. The Commission has not analyzed the potential cost of a policy to extend lifetime coverage of immunosuppressive medications to all beneficiaries, including the non-elderly, non-disabled.

The Honorable Gene Green

1. **The 340B Drug Pricing Program allows safety net providers access to discounted outpatient drugs so that they can continue to expand services offered to new and existing patients and to offset the costs of uncompensated care. However, some have raised concerns with the program, specifically in the context of outpatient oncology drugs between 340B outpatient hospitals and freestanding oncology clinics. Has MedPAC looked at the payment rates across 340 B hospitals and non 340B hospitals for cancer drugs? If so, could MedPAC comment on whether 340B hospitals get reimbursed at a higher rate than non 340B hospitals or community oncology practices for the drugs? Would you tell us about what analyses MedPAC might plan to do in this area?**

The Commission has recently begun analysis of the 340B program to understand how it functions, its growth in recent years, and its implications for Medicare. At this time, we do not have the answers to your questions. We expect to begin discussing this work publicly in the fall of 2014 and preliminary results will be shared with the Congress as the work is discussed at Commission public meetings.

The Honorable Mike Rogers

1. **In your June 2013 report, you discuss the trend of hospital acquisitions costing Medicare more and driving up costs. The report discusses in great detail how this is happening in the cardiology space. Has the Commission seen this trend in other specialties, specifically the oncology space? If not, do you plan on it?**

Has the Commission looked at what happens to patient access and costs with hospital acquisitions around different specialties? What are the benefits or costs to moving these patients into the hospital outpatient department?

We have not examined the effect of hospitals acquiring practices on patients' access and cost with regard to specific specialties. For services that can be safely provided in freestanding offices and for which beneficiaries' access is adequate, there is no benefit to patients in moving these services to OPDs, and it increases program spending and beneficiary cost sharing.

However, in our analyses we emphasize that it is safer to provide some services in OPDs than in physicians' offices. Therefore, we limit our recommendations on equal payment rates across settings to services that we believe can be safely provided in freestanding offices and where patient severity is no greater in OPDs than in freestanding offices.

2. **In January of this year, the Commission voted on recommendations around site neutrality for 66 ambulatory payment classifications. Is the Commission looking at any other codes? Do you believe CMS will act on any of these recommendations in the upcoming HOPPS and MPFS rule?**

The Commission identified the 66 sets of services using criteria to determine when it would be appropriate to equalize or narrow payments between ambulatory care settings. If other services met those criteria, Medicare could consider expanding the site neutral policy to those as well. However, CMS does not currently have the authority to implement our recommendation; doing so would require a change in law.

3. **If there was a level playing field in reimbursement in the outpatient setting, do you think that would stop or slow hospital acquisitions?**

If there is a level playing field in terms of payment in outpatient settings, we believe it would reduce hospitals' acquisition of physicians' practices. However, the extent of that reduction is unclear because other incentives still exist:

- Specialists who perform their services at hospitals may provide a reliable source of tests, admissions and referrals for their hospital.
- Accountable care organizations give hospitals incentives to acquire physicians' practices.

- Acquisition of physician practices may give hospitals greater leverage in private payer payment negotiations.

4. Have you thought about doing a single outpatient fee schedule? If so, how would you set that up? What would be the pros and cons to one outpatient fee schedule?

There may be reasons to maintain some differences in Medicare payment rates across sites of care. For many services, what is provided in hospitals is different from what is provided in freestanding offices. For these services, payment rates should be different between settings. The reasons for these differences include:

- Some services require the existence of standby capacity for handling emergencies.
- For some services, hospitals have sicker patients who may be more costly to treat.
- For many services, the outpatient payment system packages ancillary items with primary services to a greater degree than does the physician payment system. This additional packaging makes the services provided in OPDs appear more costly.

To the extent these issues are applicable, the payment rate in the outpatient payment system should be higher than the rate in the physician payment system.

The Honorable Jan Schakowsky

1. MedPAC has noted a number of times that post-acute care providers enjoy some of the highest margins in all of health care. Would you briefly comment about the margins that post-acute providers like home health agencies, skilled nursing facilities, and others receive from Medicare payments? What does this tell you about Medicare's payment for these services? What recommendations do you have for how Congress should address these high margins?

For more than 10 years, Medicare margins have exceeded 10 percent for home health agencies (HHA) and skilled nursing facilities (SNF). Inpatient rehabilitation facility (IRF) margins have declined from a high of 17.7 percent in 2003 but have remained above 8 percent since then. Long-term care hospital (LTCH) margins have been positive throughout this 10-year period but more variable, first rising to almost 12 percent in 2005 and then settling in the 6 to 7 percent range since 2009.

In 2012, the average Medicare margin for the 4 PAC settings was:

- HHA: 14.4%
- SNF: 13.8%
- IRF: 11.1%
- LTCH: 7.1%

These relatively high Medicare margins indicate that payments are more than adequate to cover the costs to treat Medicare beneficiaries. The reasons for these margins vary

slightly by sector. In the home health sector, payments are based in part on the assumption that providers will make a certain number of home visits per 60-day episode, but in reality, providers have a lower rate of visits per episode than assumed. HHAs have also been very successful at keeping their cost growth below payment updates. In the SNF sector, payments are based in part on how much therapy is provided to beneficiaries. Over time, SNFs have increasingly provided more therapy to beneficiaries, thereby qualifying for higher payment categories. Though the provision of more therapy raises costs, payments rise even faster, resulting in higher margins for higher therapy case-mix groups. For IRFs and LTCHs, larger facilities and those that controlled their costs have higher margins than other facilities.

MedPAC has made several recommendations to lower and better target Medicare's payments. For SNFs and HHAs, the Commission recommended eliminating the payment update and rebasing payments to better align payments to costs. To better target payments, the Commission recommended redesigning the prospective payment systems to base payments on beneficiary characteristics, rather than the amount of therapy provided. In March 2014, the Commission recommended reserving the LTCH payment system for chronically critically ill patients and using the acute hospital payment system for less complex patients.

2. **MedPAC has noted substantial variation in utilization patterns and patient case-mix across for-profit and nonprofit post-acute care facilities. Would you discuss what is going on here and what implications facility ownership has for provision of services? Is this an issue Congress should be interested in?**

There is variation in practice patterns across PAC settings by many factors, including ownership. In any setting, smaller facilities, which tend to be nonprofit, may benefit less from economies of scale. For-profits are more likely to be members of large chains and therefore may have more control over their input costs (e.g., volume-related discounts). Members of chains that own other types of PAC providers may have an advantage because they may be better able to control mix of patients and their lengths of stay.

In SNFs, for-profit facilities, urban facilities, and freestanding facilities tend to have higher shares of days assigned to the highest rehabilitation case-mix groups compared with other facilities, though the differences have gotten smaller over time. The increasing share of patients assigned to rehabilitation case-mix groups and, within those, the share assigned to the most intensive therapy case-mix groups, points out a fundamental problem in the prospective payment system (PPS). The PPS encourages providers to furnish more therapy as a way to boost payments. The Commission recommended revisions to the design of the SNF PPS in 2008 and, although CMS has made many changes to the PPS, this inherent bias remains. Given the bias of the PPS, beneficiaries with medically complex conditions could face impaired access to SNF care in some markets.

Among HHAs, for-profit free-standing agencies typically provide more of the highest-paid therapy services than non-profit or facility-based agencies. Similar to SNFs, the home health PPS makes higher payments for episodes with more therapy visits. This

encourages providers to deliver more visits when possible, and to avoid patients that do not require these services. The Commission recommended in 2010 that Medicare eliminate the number of therapy visits provided in an episode as a payment factor. CMS has made several changes to reduce the incentive to manipulate therapy visits to increase payment, but more visits in an episode still produce higher payments. Implementing the Commission's recommendation would eliminate this vulnerability, and safeguard access to care for patients that have care needs other than therapy.

Among IRFs, for-profit providers are disproportionately freestanding facilities rather than hospital-based facilities. Freestanding facilities tend to be larger, and therefore benefit more from economies-of-scale. Freestanding providers have also been more successful at containing their costs in recent years. As changes in the compliance threshold (the so-called 60% rule) resulted in lower patient volumes and higher severity of illness in IRF patients, freestanding facilities may have been more successful at containing costs across all components because of financial necessity among the stand-alone and predominantly for-profit facilities.

For LTCHs, in addition to the trends noted above, for-profit facilities have fewer short-stay outliers (SSO), possibly because they are selecting patients who will require longer stays or managing length of stay to ensure patients stay long enough to trigger a higher Medicare payment. Nonprofits have more high-cost outliers, but it's not clear whether this is due to differences in efficiency or case complexity or both.

The Honorable Gus Bilirakis

1. **In the testimony of Dr. Brooks, he talks about how 1,338 community cancer centers have closed, consolidated or reported financial problems since 2008. This would seem to be a disturbing trend. Has MedPAC noticed a pattern of decreased community oncology centers and an increase in hospital outpatient cancer services?**

To date, we have not tried to analyze such a pattern. However, each year we monitor changes in volume and setting of health care services for Medicare beneficiaries, as well as beneficiary access to physician services, and report those findings to Congress in our March report.

2. **If community oncology practices close, diminish, or reopen as a Hospital Out-Patient Department, will this have a corresponding increase in Medicare spending because of the higher payment schedule? If so, do you have an estimate of how much?**

The closing of community cancer centers could result in billing of oncology services shifting from freestanding offices to OPDs. To the extent that OPD rates are higher than rates in physicians' offices, Medicare spending would increase. We do not have an estimate of the effect of a shift of oncology services from community practices to OPDs on Medicare spending.

The Honorable Tim Murphy

1. **I frequently hear from hospitals and physicians saying that the reimbursement rates for Medicare do not cover their costs sufficiently. But based on a number of reports, it appears some providers are also making money on the 340B program. Has MedPAC done any work examining this as another payment disparity between different types of providers at different sites of service? What considerations are relevant for Congress on this issue?**

The Commission has recently begun analysis of the 340B program to understand how it functions, its growth in recent years, and its implications for Medicare. At this time, we do not have the answers to your questions. We expect to begin discussing this work publicly in the fall of 2014 and preliminary results will be shared with the Congress as the work is discussed at Commission public meetings.

2. **We have heard concerns about people without insurance or who have Medicaid and what their outcomes look like compared to individuals with private insurance. For example, the survival rates are very different for people with different coverage who have cancer. But, according to the Cancer Medicine Journal, it is due to a complex set of demographic and clinical factors, of which insurance status is just a part. But I want to look at this in terms of Medicare, based on where a person actually gets their care: a hospital base compared to a physician's office. Are you aware of any clinical literature, or has MedPAC done any work, examining the differences in medical outcomes or survival rates based on where the care was delivered?**

MedPAC has not done any analysis comparing differences in outcomes between ambulatory settings, and we are not aware of any literature that examines this issue. Because of the variation in the types of services provided in ambulatory settings (e.g., office visits, procedures, tests) and the limited clinical information reported on Medicare claims, it would be difficult to define relevant clinical outcomes for patients in these settings.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Majority (2021225, 7927)
Minority (2021225, 3641)

June 11, 2014

Dr. Barbara J. Gage
Managing Director
Engelberg Center for Health Care Reform
The Brookings Institute
1775 Massachusetts Avenue, N.W.
Washington, D.C. 20036

Dear Dr. Gage:

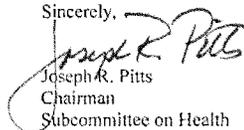
Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



**“Keeping the Promise: Site of Service Medicare Payment Reforms”
Testimony on the Committee on Energy and Commerce, Subcommittee on Health
Additional Questions for the Record**

Submitted by
Barbara Gage, PhD, Fellow, Engelberg Center for Health Care Reform
The Brookings Institution
June 25, 2014

Chairman Pitts, Ranking Member Waxman, thank you for the opportunity to provide additional information to the Committee on payment reforms for Medicare post-acute care (PAC). The questions you raise are important for understanding the impact of changes in post-acute care on the larger Medicare program.

The Honorable Joseph R. Pitts

1. In your testimony, you said that almost one in five Medicare beneficiaries is admitted to the hospital each year. Do you see PAC reforms as a way to better manage care, lower Medicare beneficiaries’ costs or something else?

Yes, PAC reforms, particularly in the context of the national Triple Aim which is targeting improved quality and population health as a means of reducing healthcare costs, can improve both the patient experience and reduce the program costs. The PAC populations are among the most complex and costly in the Medicare program. Establishing mechanisms that improve coordination and communication among the multiple providers will improve both the care and outcomes for the patient; improve the patient experience, including their understanding and compliance with the directions provided by physicians, surgeons, and other healthcare professionals, and highlight their role in achieving better outcomes. These tools will also reduce inefficiencies associated with redundant tests, preventable rehospitalizations, and other adverse events that could be avoided if better patient management such as medication reconciliation and care management practices were in place.

2. In your testimony, you suggested that collecting standardized data nationally for two years prior to finalizing payment system changes to increase the sample size for less common cases and reduce the uncertainty associated with changes in the payment system. What should happen after two years?

National, standardized data should replace the analogous items currently in the individual assessment tools. By replacing analogous items in the existing tools you can minimize the data collection and information technology (IT) burden on providers as you will not be changing their processes but substituting the reliable, standardized terminology for the analogous items. Substituting the standardized items into the existing assessments also will allow the data to be exchanged electronically among providers, regardless of system affiliation. To develop the revised, finalized payment systems, a 2 year transition period may be necessary in which both the current and the standardized items are collected. This will allow providers to continue to be paid under the current system while the payment models can be refined based on the more complete 2 years of national data. After two years of national data collection on all Medicare beneficiaries, MedPAC and CMS should have adequate data to finalize the revised payment systems and to shift on-going data collection to only the standardized items.

Work is currently underway to examine refinements to the PAC payment models using the PAC PRD standardized data. This work will provide important exploratory information for determining clinically and statistically significant factors to include in the final payment models. These models will need to be refined with the larger national data set to establish fair and equitable coefficients across all PAC populations. But after 2 years of collecting the standardized data and the current data, the Medicare program should have adequate data and time to finalize the payment system changes, and shift to the standardized assessment items in place of the analogous current items. By replacing analogous items in the current assessment tools with the standardized versions of those items, but leaving the rest of the tools and procedures in place, the burden on the providers will be minimized. The current assessment tools contain not only the types of items that have been standardized to measure patient complexity and risk factors but also include some additional

items providers use for care management and planning. Substituting items, rather than replacing tools, will allow these processes to continue with less disruption in patient care.

3. You noted that hospitals are trying to predict readmission rates using internal data systems, but because each hospital uses its own version of these items, hospital outcomes cannot be compared across the local market. What steps do you think can be taken by Congress or CMS to improve HospitalCompare.gov and make it a more meaningful experience for users?

The HospitalCompare.gov website provides valuable information for patients to select hospitals by providing information on hospital experience for patients with conditions similar to the seekers. The data on Medicare spending per beneficiary and average outcomes, including risk of 30 day rehospitalizations, inpatient infections and complications is also useful for comparing hospital effectiveness in these outcomes areas. However, most of the measures are related to inpatient experience.

The PAC populations, by definition, are continuing their treatments by being transferred to additional providers. Information on effective transitions, including process measures on communications between discharging and admitting physicians, information transfers to primary care physicians, and the use of care managers to oversee a safe transition between settings during an episode of care, are but a few measures that could begin to address these issues and show each hospitals' effectiveness in safely transitioning the patient out of their setting. Ideally, standardizing the information needed by the patients' other team members would allow efficient transfer of information regardless of each hospital's underlying IT system. The health information technology (HIT) community has been developing the electronic standards to transfer information across IT systems, regardless of the individual item content or the surrounding IT system. Interoperable data systems such as those developed by the ONC-funded IMPACT grant in Massachusetts are providing prototypes for hospitals to be able to exchange data to skilled nursing facilities and other providers that are not part of their organization but which are receiving the patient at discharge.

4. Would you offer your perspective on private sector efforts to give consumers tools that compare cost, quality, or outcomes for providers? I am thinking of efforts by companies like Castalight, or US News and World Reports, or Leapfrog?

These are important initiatives. Groups like Leapfrog were among the earliest in trying to develop ways to compare the effectiveness and costs of care across providers in a local market. The US News and World Reports are another attempt to compare hospitals in several areas. The employer communities have also been working on these issues to better inform their beneficiaries in the self-insured markets. Each of these efforts is contributing to making information available and helping their patient populations better understand factors for selecting providers.

5. Medicare is currently facing insolvency, which would jeopardize care for millions of seniors that depend on the program. What policies or payment reforms would you recommend Congress consider to help keep the promise to seniors by saving Medicare from insolvency?

Establishing better practices to manage the patient across the episode of care is critical to both improving patient care and outcomes and enhancing program efficiencies. Managed care did not live up to its potential during the earlier years because they focused on cost-containment and utilization restrictions without attention to quality and outcomes. Advances in measurement science have led to a growing library of valid and reliable outcome measures that can be applied to the utilization management rules. Incorporating minimum quality standards, both outcome metrics and evidence-based process measures that impact outcomes, into value-based payment policies can correct for the shortcomings in the managed care programs that have evolved over time. Many value-based or performance-based payment policies are being used in both the private and public sector, including accountable care organizations, medical homes, bundled payments, and even the fee-for-service programs that reduce payments for poor quality, such as Medicare's acute IPPS program. Quality requirements, tied to payment incentives are key to the success of patient management initiatives that ensure access to appropriate care is maintained, particularly for the more complex PAC populations.

6. What do you think about the possible savings to the beneficiaries if Congress were to combine the A/B cost-sharing and adopt a catastrophic cap? This reform has been recommended by MedPAC, former Sen. Lieberman, and the President's Fiscal Commission.

This approach introduces important factors affecting not only the beneficiaries' out of pocket costs but also potentially reducing the program costs. As currently structured, the Medicare cost-sharing structure lacks protection for those at the greatest risk. Establishing a catastrophic cap will protect the most vulnerable populations with the greatest need for insurance protection. The second half of the proposal, to combine the A/B cost-sharing may have a limited effect on beneficiary savings, in terms of changes in out-of-pocket costs, but would shift the beneficiary's awareness to consider the use of more discretionary services. The current structure provides better coverage for relatively more discretionary Medicare services, such as physician care which reduces the patient's incentive to consider the need for each individual visit. On the other hand, for the lower income populations, these incentives already exist. And it is important to remember that while physician services may be more discretionary than hospital services, particularly emergency services, the majority of physician services may not be discretionary.

The Honorable Henry A. Waxman

1. Under the current Medicare payment systems, there are no financial incentives for hospitals to refer patients to the most efficient or effective setting so that patients receive the most optimal but lowest cost of care. Whether a patient goes to a home health agency or skilled nursing facility, for example, seems to depend more on the availability of PAC settings in a local market, patient and family preferences, or financial relationships between providers. Since patients access PAC care after a stay in the hospital, how can we best harness the hospitals to help ensure patients receive care in the right setting after a hospital stay?

Hospitals need to be part of the team but they also should not dictate treatment setting decisions. The hospital clinicians are in the best position to identify the types of services the patient could benefit from following their hospital treatment. However, they also need to communicate about the patient complexity to the receiving set of clinicians. Currently, the clinical team making the recommendations about PAC needs include the hospital physicians, both the attending or hospitalist and surgeon with their expectations of healing trajectories, and the hospital nursing staff who make recommendations to the hospital discharge planning staff about PAC resource intensity needs. The discharge planner is responsible for working with the local PAC providers to identify available beds in settings that meet the clinical team's recommendations. If the patient has physical medicine and rehabilitation needs, the discharge planner also needs input from the therapy team regarding appropriate care. However, short term acute hospitals rarely provide the therapy to the patient following surgery; instead the patient is referred to PAC, either by being transferred in-house to a bed certified as part of an inpatient rehabilitation unit or skilled nursing facility/transitional care unit or by being discharged to an independent IRF, SNF, LTCH, or home health agency, depending on the complexity of the case and the type and intensity of resources needed. In many areas of the country, a PAC clinical liaison from the local PAC providers work with the hospital discharge planner to review the patient chart and determine appropriateness for their level of care (LTCH, IRF, SNF or HHA). A joint decision is made between the hospital discharge planner who has the recommendations of the in-house clinical team and the PAC liaison that has the experience with their level of care to determine if the patient is a match. Because each of these parties has an incentive to "win" the patient, economic theory suggests the best arbiter is an "agent" or someone who is independent of the service delivery. This is referred to as a conflict-free case-manager or someone who has nothing to gain by the PAC destination decision. Instead they can focus on the best option for meeting the patient's desired outcomes.

The hospital's role in this team is to communicate with the experts that will be working with the patients at the next stage of service so that the receiving team understands the complexity and limitations of the case as they consider appropriate treatment plans. Passing standardized assessment information from the hospital

to the PAC provider will create the timely and effective information transfer needed to provide the least expensive, most effective treatment plan for meeting the desired outcomes.

2. In your testimony, you note that the probability and type of PAC services used at hospital discharge can be partially explained by the reason for hospitalization. The draft bipartisan legislation released by the Ways and Means Committee proposed that standardized data on patients is collected across PAC settings, including in the hospital. I understand that hospitals may have concerns with also being required to collect this data. What is your view on which entities should be collecting this patient specific data?

All entities treating the patients and making clinical decisions based on the information should be collecting the same type of information, regardless of setting. As an example, if a hospital patient's treatment is complicated by the presence of a stage 3 pressure ulcer following surgery, that information needs to be communicated at the "handoff." That communication is facilitated by using the same terminology and definition of a stage 3 pressure ulcer, regardless of setting. Second, if the care manager is using the input of the clinical team to determine the most appropriate PAC setting, they need to do so before a patient is discharged to a PAC setting. Otherwise, the patient is at greater risk for experiencing complications while being transferred unnecessarily among providers and the system is experiencing costs that could have been avoided, such as multiple ambulance rides and adverse events that occur en route between settings.

Thank you for the opportunity to address your additional questions. I can be reached at bgage@brookings.edu if you would like to reach me.

Barbara Gage, PhD, MPA

Fellow, Engelberg Center for HealthCare Reform

Economic Studies, The Brookings Institution

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CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

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June 11, 2014

Dr. Barry Brooks
Chairman
Pharmacy and Therapeutics Committee
The U.S. Oncology Network
7777 Forest Lane, D-400
Dallas, TX 75230

Dear Dr. Brooks:

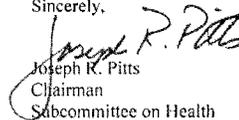
Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

 **The US Oncology
Network**

June 25, 2014

The Honorable Joseph R. Pitts
Chairman
Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts,

Thank you again for the opportunity to testify in the Energy and Commerce Subcommittee Hearing on "Keeping the Promise: Site of Service Medicare Payment Reforms" on May 21, 2014. I have attached my responses to the questions submitted for the record from the hearing.

If you have any questions or concerns please do not hesitate to contact me. Thanks again.

Sincerely,

Barry Brooks

Barry Brooks, MD
Chairman of the Pharmacy and Therapeutics Committee
The US Oncology Network

Dr. Barry Brooks Response to Questions
Energy and Commerce Subcommittee on Health Hearing
"Keeping the Promise: Site of Service Medicare Payment Reforms"
May 21, 2014

The Honorable Gus Bilirakis

- 1) I hear from oncologists in my district and other parts of Florida who are struggling due to the lack of payment parity with hospitals and continued sequester payment cuts to cancer drugs. I am very concerned that the consolidation of cancer care is driving up costs for Medicare and what this means for seniors on fixed incomes. A recent report by the Institute for Healthcare Informatics states, "sites of care that increase patient contribution and cost sharing may actually lead to a significant increase in the total cost of care." Stakeholders are questioning the sustainability of the rapid growth among hospital outpatient facility settings for oncology drug administration. How can we preserve choices so that our seniors have options when seeking treatment?

To ensure patient choice in cancer treatment it is essential that Congress alleviate some of the pressures on community oncologists. Currently, there are several hospital based incentives that are driving the acceleration of hospitals purchasing struggling community oncology offices. Right now hospital outpatient departments receive double the reimbursement for the exact same services than the physician setting, many receive large 340B discounts on expensive cancer drugs, hospitals can write off or get reimbursed by Medicare for their uncollected coinsurance and a large number of hospitals are currently exempt from state and federal taxes. These advantages that the hospitals enjoy create an unlevel playing field that limit the economic viability of community oncology and make it difficult to even keep their doors open to patients.

Congress has introduced several ideas to help alleviate the pressure on community physicians as well as level the playing field in the outpatient setting. Congressmen Ed Whitfield and Gene Green have introduced H.R. 800 to remove the prompt pay discount from the physicians Medicare reimbursement. This is a discount between a manufacturer and distributor that is not passed on to the provider. Removal of this discount would ensure proper reimbursement for a drug that the physician has already purchased.

Congresswoman Renee Ellmers has introduced H.R. 1416, which would remove the sequester cut from the full reimbursement on cancer drugs. Physicians actually took a 27% cut to their reimbursement when CMS decided to apply the 2% sequester cut on the full ASP+6% instead of the 6% that is the actual reimbursement to the doctors (resulting in ASP +4.3%). As cancer providers we understand the need to save money in the health care system, but cancer providers are taking a much larger hit on the drug side of sequester than providers in other professions.

Most importantly, Representative Mike Rogers and Doris Matsui introduced H.R. 2869 to level the playing field and provide a uniformed payment for cancer services in the

outpatient setting. According to the same IMS Institute for Healthcare Informatics (IMS Inst.) study¹ you reference in your question, of the 10 most common chemotherapy treatments hospital outpatient departments charged 189% more than the same infusions would cost in the physician setting. H.R 2869 would provide equal payments for the same service regardless of outpatient setting.

Building subsidies into HOPD payments for cancer care services to cover hospitals' indirect expenses associated with standby services does not appropriately target the added resources to those services. It also distorts pricing for outpatient cancer services that require the same level of resource commitment regardless of the site of care. Such subsidies in combination with other site-specific Part B drug payment and policy issues have been major contributors to the rapid increase in hospital employment of physicians in general, and oncologists in particular. By breaking down some of the barriers in the cancer care delivery system and passing the three above mentioned bills, I believe Congress would go a long way to ensure choice and access to our nation's seniors struggling with cancer.

2) In your testimony, you mentioned that hospitals receive Medicare payments to offset bad debt from non-payment, but that physician offices do not receive payments. How much bad debt do you deal with and how does that affect your business?

It is rare for physician practices to be able to collect the entire Medicare allowable rate for Part B drugs and services because of the 20% coinsurance obligation facing beneficiaries, often for very expensive therapies. The experience of the US Oncology Network has been that approximately 25% of the coinsurance amounts (approximately 5% of the Medicare allowable) due to practices are uncollectible and end up as a direct expense of the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.

3) If a community oncology practice is acquired by a hospital, they can reopen the same facility as a Hospital Out-Patient Department. A patient could go to the same facility, see the same physicians, use the same equipment for the same treatment, but receive a different bill – increased bill – from the center. This could be a significant sticker shock for the beneficiary. Would you talk about how much of an increase in cost the beneficiary could see?

Unfortunately, the scenario you are portraying is happening all over the country. A large percentage of physician's offices that are acquired by the hospitals face this very problem. The May 2014 IMS Inst. report calculated that for commonly used cancer drugs, the average increased cost to the patient is \$134 per dose if received in a hospital outpatient setting rather than in an oncologist's office. And patients frequently receive multiple therapies at once which would result in a significant increase in financial burden to the patient.

¹ IMS Institute for Healthcare Informatics, *Innovation in Cancer Care and Implications for Health Systems: Global Oncology Trend Report* (May 6, 2014)

As far as sticker shock, a new Berkley Research Group study² titled, "Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration," estimates that Medicare payments were \$23.29 million higher between 2009 and 2012 for the services delivered in the hospital outpatient departments due to hospital acquisition of community cancer practices. Patient costs were also found to be significantly higher, with Medicare beneficiaries paying an additional \$4.05 million in out-of-pocket costs during that same timeframe. Researchers at BRG also examined the expansion of the delivery of oncology services by 340B hospitals in recent years through the acquisition of community cancer practices. The study found that of the 340B hospitals they identified as acquiring a community cancer practice between 2009 and 2012, Medicare and Medicare beneficiary payments on chemotherapy claims increased by an estimated \$167.28 million.

A 2011 Milliman study finds that the cost of treating cancer patients is significantly lower for both Medicare patients and the Medicare program when performed in community clinics as compared to the same treatment in the hospital setting.³ The study shows HOPD-based chemotherapy costs Medicare \$6,500 more per beneficiary (over \$623 million) and seniors \$650 more in out-of-pocket spending per patient annually.

Alarming, the IMS Inst. report also mentions that patients who face higher out-of-pocket costs are more likely to drop out of treatment, citing a study showing that a bump of as little as \$30 in co-pays caused some breast cancer patients to skip or discontinue care.

So when a hospital acquires a physician's office and just changes the name on the door, patients see a drastic shift in their medical bills which in turn could discourage the patient from even seeking cancer care services. Congress should act quickly to discourage such practices and encourage a level playing field between the two settings of care.

The Honorable Gene Green

- 1) **My understanding is that we are talking about whether there is a need for site neutrality as it relates to payment for the administration of cancer drugs, not payment for the cost of drugs themselves. Is it not true that Medicare pays hospitals and private practices the same rate for the cost of their drugs? Given that the 340B program is about discounts on the cost of drugs, and not payment for the administrations of drugs, it seems to me that this program would have nothing to do with site neutrality.**

Do you have any evidence that 340B hospitals are buying up community-based oncology practices at any greater rate than non 340B hospitals? How much uncompensated care does the average community-based oncology practice provide as compared to the average 340B hospital?

² 2014 Berkley Research Group Study "Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration," June 2014

³ K. Fitch and B. Pyenson, Milliman Client Report, *Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy* (Oct. 19, 2011), available

It is correct that the Medicare pays hospitals and private practices the same rate for the *acquisition* cost of oncology drugs (Average Sales Price plus 6%). As I mention in my testimony, hospital outpatient departments are paid substantially higher rates compared to private practices for the *administration* of these drugs, which leads to substantially higher payments incurred by the Medicare program, the Medicare beneficiaries, and the American taxpayer. In fact, according to a June 2014 Berkley Research Group Study “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,”⁴ of the eighty-six 340B hospitals that acquired a physician’s office between 2009-2011 it is estimated that the Medicare program paid \$23.29 million and Medicare beneficiaries paid \$4.05 million more than they otherwise would have had the services been performed in the physicians’ offices.

In addition to these code and service specific payment differentials outlined by MedPAC in their site-neutral policy recommendations to Congress in the June 2013 Report⁵ to the Congress, hospitals enjoy other advantages relative to government policies around Medicare Part B drugs that push more patients and physicians into that setting. I mentioned the 340B program in my testimony because it is one of the primary compounding factors that results in an unlevel playing field within outpatient cancer care and most certainly has contributed to the dramatic increase in the acquisition of community based cancer clinics by hospitals.

Approximately one-third of US hospitals purchase chemotherapy drugs through the 340B program at discounts of up to 50%, typically more than 30% below the Medicare reimbursement rate in the physician setting. For 340B hospitals, the margin on Medicare drugs is over 30%, while the community clinics margin is zero to negative 2%. For evidence of the effect the 340B program has had on community based oncology clinics I reference the April 2014 Berkley Research Group Study titled, “340B Covered Entity Acquisitions of Physician-based Oncology Practices.”⁶ The studies key findings include:

- Acquisitions of physician-based oncology practices by 340B covered entities increased significantly over the 2009-2012 time period included in the study; and more recent data indicates this trend continued in 2013.
- The average volume of oncology-related 340B chargebacks at covered entities that acquired a physician-based oncology practice (“Acquiring Covered Entities”) was comparable to those entities that did not acquire a physician-based oncology practice (“Non-Acquiring Covered Entities”) in 2009, but grew to be three times greater than Non-Acquiring Covered Entities by 2012. The vast majority of this growth is attributable to 340B purchases by the acquired physician-based oncology practices (“Acquired Sites”).

⁴ 2014 Berkley Research Group Study “Impact on Medicare Payments of Shift in Site of Care for Chemotherapy Administration,” June 2014

⁵ MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013).

⁶ Berkley Research Group Study titled, “340B Covered Entity Acquisitions of Physician-based Oncology Practices”, April 2014

- The amount of average yearly 340B chargebacks included in this study did not appear to correlate with the volume of charity care provided by the Acquiring Covered Entity. Indeed, 45% of the covered entities included in the study generated more oncology-related chargebacks than they reported in total charity care costs for the same fiscal year, thereby recouping more than their self-reported total charity care costs with just the chargebacks obtained on this subset of oncology products. This disparity would be even greater had the study examined chargebacks obtained across the hospitals' entire 340B purchases.
- The majority of the Acquired Sites reviewed in the study (83 of 144) were located in communities with higher median-incomes than that of the Acquiring Covered Entity, while only 14 Acquired Sites were located in communities with a lower medium income than that of the Acquiring Covered Entity.

The Community Oncology Alliance has been tracking the closure, consolidation and reported financial problems of community cancer clinics for a number of years. According to a report published in June 2013, 70% of the 407 oncology physician practices that affiliated with hospitals in the previous 3 years did so with 340B covered entities, even though only a third of all hospitals in the nation participate in 340B.

With respect to uncompensated care, the experience of The US Oncology Network has been that approximately 25% of the coinsurance amounts (approximately 5% of the Medicare allowable) owed to practices are uncollectible and end up as a direct expense to the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.

FRED UPTON, MICHIGAN
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HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
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COMMITTEE ON ENERGY AND COMMERCE
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Minority (502) 225-3841

June 11, 2014

Dr. Reginald W. Coopwood
President and CEO
Regional Medical Center
877 Jefferson Avenue
Memphis, TN 38103

Dear Dr. Coopwood:

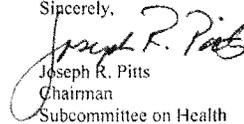
Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



Liberty Place, Suite 700
 325 Seventh Street, NW
 Washington, DC 20004-2802
 (202) 538-1100 Phone
 www.aha.org

Responses from the American Hospital Association

“Keeping the Promise: Site-of-Service Medicare Payment Reforms”

May 21, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association’s (AHA) appreciates the opportunity to provide additional feedback on the hospital perspective on site-of-service payment proposals. Please find below our answers to specific questions posed by Subcommittee Members.

THE HONORABLE JOSEPH R. PITTS

1. The AHA agrees that Medicare insolvency would jeopardize care for millions of seniors who depend on the program. The longer Congress waits to address Medicare insolvency, the more difficult it will become to address the situation. We urge the Congress to address this issue sooner rather than later. To this point, the AHA has published and disseminated a list of “[Deficit Reduction Alternatives in Health Care](#).”
2. The AHA agrees that cost savings to Medicare beneficiaries under a combination of the Part A and B benefits with a catastrophic cap, as recommended by the Medicare Payment Advisory Commission (MedPAC) and the President’s Fiscal Commission, should be considered as an alternative to further cutting provider payments, which could in turn impede beneficiary access. For this reason, we included this in the list of deficit reduction alternatives referenced above.

THE HONORABLE MIKE ROGERS

1. The AHA does not track those numbers. In terms of valuation, spending and acquisition, U.S. Oncology was acquired by McKesson for \$2.16 billion in 2010. At the time, U.S. Oncology distributed \$2.4 billion in oncology pharmaceuticals annually (Medicare pays an additional 6 percent above the Average Sales Price for drugs administered by U.S. Oncology). Under your legislation, the Moran Company estimates the \$2.9 billion you would cut hospital cancer care for patients over 10 years would all go to free-standing cancer sites.



In fact, hospital outpatient departments (HOPDs), as you know, have much more comprehensive licensing, accreditation and regulatory requirements than free-standing physician offices. This includes hospital licensure requirements in all states, Medicare conditions of participation, and additional oversight and regulation by a large number of other government agencies such as the Food and Drug Administration, Environmental Protection Agency and Occupational Safety and Health Administration, to name a few. These same standards are not required of physician offices, but must be complied with when billing Medicare as an HOPD.

2. Physicians refer sicker and more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a higher average risk for complications. An AHA analysis of Medicare data demonstrates that patient severity is nearly 24 percent higher in HOPDs than in physician offices.

But the fact is, patients often cannot find care at free-standing cancer sites. Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations. Your proposed reduction in outpatient Medicare revenue to hospitals would threaten access to critical hospital-based services, such as care for low-income patients and services for patients with multiple conditions. HOPDs serve a higher percentage of dual-eligible patients (28 vs. 19 percent) than physician offices. HOPDs also serve a higher percentage of disabled patients (23 vs. 15 percent) and non-white patients (20 vs. 14 percent).

3. Payment should reflect HOPD costs, not physician payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule (PFS) (and, specifically, the practice expense component) is based on responses to physician survey data held flat for years due to the cost of various physician payment "fixes." Physicians widely agree that the Medicare PFS underpays for their services, but as you will recall from MedPAC's testimony at the hearing, their site-neutral payment proposals all reduce payment to those PFS levels.

Furthermore, capping these payments would lead to distortion of the hospital outpatient payment system and the outpatient ambulatory payment classification (APC) relative weights due to the artificial payment caps that are no longer related to hospital costs. Each APC has a relative weight based on the geometric mean cost for the procedures in the group relative to the geometric mean cost for a mid-level clinic visit.

4. Hospitals have greater costs than physicians providing the same service in their offices. HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional

combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.

Unpaid “stand-by capacity” costs – such as around-the-clock availability of emergency services; cross-subsidization of uncompensated care, EMTALA and Medicaid; emergency back-up for other settings of care; disaster preparedness; a wide range of staff and equipment – make hospital-level care more expensive, and these costs are spread across all hospital services, including outpatient E/M services.

5. Hospitals already lose money treating Medicare patients in HOPDs. According to MedPAC’s March 2014 report, Medicare margins were *negative* 11.2 percent for outpatient services in 2012. Additional cuts to HOPD payments threaten beneficiary access to these services. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.

Cutting care for cancer patients, when HOPDs are already underpaid by 11.2 percent, would jeopardize seniors’ ability to find cancer care at a time they are most vulnerable, which is why the AHA opposes this proposal.

6. The 340B Drug Pricing Program was established to help safety-net health care providers stretch scarce resources, enabling improved patient access to pharmaceuticals and allowing more hospitals to provide comprehensive services. The need for such a program became apparent after the establishment of the Medicaid rebate program in 1990. Pharmaceutical companies stopped providing discounts on drugs sold to non-Medicaid providers, which resulted in higher drug costs for many safety-net health facilities caring for the nation's most vulnerable patient population. As a result of this market change, Congress, with broad bipartisan support, enacted the 340B Drug Pricing Program to provide safety-net health care facilities relief from high prescription drug costs. Since the program's inception, Congress expanded the program to additional safety-net hospitals, thereby enabling improved health care access to more low income and uninsured patients.

There are variety of ways hospitals use the program to benefit the patients and communities they serve. The notion that 340B is a main driver of consolidation in the oncology field is misguided. Larger market forces have influenced independent oncology practices to merge with their community hospitals. Hospitals are strengthening ties to each other and physicians in an effort to respond to new global and fixed payment systems, as well as incentives for improved quality and efficiency, implementation of electronic medical records, and care that is more coordinated across the continuum.

Hospitals and their outpatient departments receive higher payment rates due to their additional capabilities and requirements. Hospitals care for all patients who seek emergency care, regardless of their insurance status or ability to pay; maintain standby disaster readiness capacity in the event of a catastrophic occurrence; and treat patients who are sicker and require more complex services than those treated by private practice oncology clinics.

Hospitals face many challenges to maintain the full panoply of services that the public expects to receive when they are sick and need care 24/7 – challenges that are not confronted by private practice oncology clinics. Increased demand for specialized services, staffing shortages, diminishing financial support from Medicare and Medicaid, capital expenses, increased accreditation requirements, and greater expectations for emergency preparedness are just a few of the challenges hospitals face. Given all of these additional requirements, the cost of providing care in a hospital outpatient oncology department is far greater than that of a private practice oncology clinic. It is important to note that 340B discount prices help eligible hospitals meet the needs of their patients regardless of their insurance status. Hospitals' ability to use 340B to stretch their scarce resources is vital given the additional requirements placed on hospitals.

THE HONORABLE GENE GREEN

1. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in the Medicaid drug rebate program to sell outpatient drugs at discounted

prices to taxpayer-supported health care facilities that care for uninsured and low-income people. The 340B program enables eligible entities, including hospitals and community health centers, to stretch scarce federal resources to reduce the price of pharmaceuticals for patients, expand services offered to patients and provide services to more patients. In addition, the program generates savings for both the federal and state governments.

The program allows these hospitals to further stretch their limited resources and provide additional benefits and services to their communities. For example, Regional One Health uses the savings realized from its participation in the 340B program to expand pharmaceutical access to uninsured patients. The 340B program helps to offset the health system's costs of providing free medications to patients. In addition, the savings from the 340B program are used for a home-based IV program for vulnerable patients, provide operational support for medication assistance programs, and support pharmacy operations in the outpatient HIV clinic.

If the 340B program did not exist or was sharply scaled back, many of the hospitals that currently benefit from the program would lose their ability to provide enhanced care to their patients and the communities they serve. Many of the services supported by the 340B program at hospitals like Regional One Health could be put in jeopardy if drastic changes were implemented in the 340B program. As a result, patient care would suffer.

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2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 226-2927
Minority (202) 226-3943

June 11, 2014

Dr. Steven Landers
President and CEO
Visiting Nurse Association Health Group
176 Riverside Avenue
Red Bank, NJ 07701

Dear Dr. Landers:

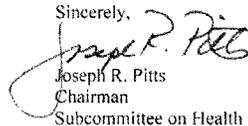
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Attachment—Additional Questions for the Record

**Responses to E&C Questions by Dr. Steven Landers
President & CEO
VNA Health Group**

- 1) Shifting more long-term care and post-acute care services into the home setting should result in lower costs and better care experience. The per user costs for home-based care will certainly be lower than institutional care users. The risk of an unsustainable increase in utilization are more apparent in a fee for service model, and these risks should be diminished by moving to a value-based bundled payment model, such as the Bundling and Coordinating Post Acute Care (BACPAC) model recently introduced by Reps. David McKinley and Tom Price, where the providers must generate savings from the expected costs in order to succeed, thereby achieving alignment of between the payment model and the policy goal of cost reduction. In addition, we strongly recommend adoption of targeted program integrity reforms — such as those which we have proposed in the *Skilled Home Healthcare Integrity and Program Savings (SHHIPS) Act* (summary attached) — which we believe would be very effective in preventing the utilization issues about which the Committee is properly concerned.
- 2) Although I have no direct experience in post-acute care bundled payment models (largely because the model does not yet exist in Medicare), I have a lot of experience in the current fragmented and poorly aligned post-acute system. Based on this experience, I believe there is strong evidence that enhanced care coordination and new payment incentives could result in lower costs and better care. In managed care arrangements that are more flexible, I have seen how nursing facility length of stay can be reduced through enhanced care coordination and expanded home and community-based options. These arrangements were not bundled models, but the incentives more closely matched those in the proposed bundled payment arrangements than the fee for service program.
- 3) At present, the Medicare program specifically excludes telemedicine services to the patient's home. Current policy does permit-home health agencies to use telehealth monitoring as a means to improve quality and efficiency when ordered by the treating physician — however, the Medicare program currently does not provide any reimbursement to home health providers for the deployment and use of such technologies. There is also seemingly contradictory policy guidance that these telehealth services cannot replace any covered home health visits. By explicitly supporting the use of new mobile and digital technologies as a strategy within a post-acute bundle, providers will be empowered to find ways to use such technology to enhance access and connectedness with patients while lowering costs. In addition, the BACPAC proposal explicitly permits the use of savings to fund investments — such as care delivery and management technologies — that can improve outcomes and efficiency.
- 4) Helping the high risk, high cost beneficiaries succeed at home is the best strategy for lowering costs while promoting dignity, independence, and keeping families in-tact. Post-acute reforms, such as BACPAC, that promote enhanced home care within an accountable payment model are very promising. Indeed, the BACPAC model is structured to capture substantial savings by establishing that total program spending may not exceed 96% of the applicable baseline, thereby ensuring that billions of dollars in savings will be achieved. I am also very enthusiastic about the impact of in-home primary medical care in an analogous shared-savings model to the Independence at Home Demonstration Program that is currently being tested by CMMI. The Independence at Home Model has been studied in the VA system as well as in several communities and managed care plans and it shows substantial savings to Medicare by increasing home-based care resources. The overall cost of care is lowered due to reduced hospitalization and institutionalization.
- 5) I believe combining A/B cost-sharing would add new barriers to home health care and result in more unnecessary and costly hospitalization and institutionalization. Past efforts to include co-pays for home health care resulted in more emergency room and hospital use. As the Committee is aware, the Medicare home health benefit was subject to cost-sharing from the program's inception in 1965 until 1972 — when Congress explicitly repealed this policy due to the fact that it was indeed causing the program to bear greater institutional treatment costs and placing an unsustainable burden on the beneficiaries who, per Medicare data, are older, poorer, sicker and more likely to be female and minority than all other Medicare beneficiaries combined. Combining A/B cost-sharing would therefore pose the very same risks as the failed policy which Congress wisely repealed, unless the reform you're suggesting could be designed to be accomplished without adding new barriers to home health care.

www.homehealth4america.org

Skilled Home Healthcare Integrity and Program Savings Act (SHHIPS)

The Partnership for Quality Home Healthcare has been working for more than a year to develop policy solutions that are designed to protect Medicare beneficiaries, cost-effective providers, and American taxpayers by preventing fraud and abuse before it occurs.

The SHHIPS proposal is largely based on a successful precedent to prevent aberrant outlier payments. In 2009, the home health community proposed that a 10 percent cap be placed on Medicare outlier claims to stem what

was considered an example of unchecked fraud and abuse. Adopted by the Centers for Medicare and Medicaid Services (CMS) and included in the Affordable Care Act (ACA), this single reform is on track to generate a total of 11 billion in taxpayer savings over the next decade.

Building on the positive outcomes of its outlier proposal, the home health community has developed a comprehensive set of additional program integrity reforms.

Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse

- Prevent entry of individuals with criminal backgrounds: Require criminal background checks for all home health employees with direct patient contact or access to patient record
- Verify competency through improved standards: Require background screening of owners and managing employees
- Enforce provider integrity: Require providers to have a compliance and ethics program to prevent and detect criminal violations
- Ensure operational capacity to serve beneficiaries: Require all new providers to secure a 100,000 surety bond
- Temporary entry limitations to prevent excess growth: Suspend issuance of new provider numbers in over-saturated counties

Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value

- Prevent payment of aberrant claims: Limit reimbursement of episodes to an aggregate annual per-provider average based on beneficiary location and establish a minimum annual Low-Utilization Payment Adjustment (LUPA) claim rate of 5 percent
- Ensure accuracy of all claims: Establish a uniform process to ensure claims are valid prior to payment

Quality Outcomes Improvement

- Improve care planning for Medicare skilled home healthcare services: Permit non-physician providers, operating under a physician's direct supervision, to complete initial patient assessments and coverage certifications to ensure beneficiary access to care

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Minority (202) 225-3641

June 11, 2014

Mr. Peter Thomas
Principal
Powers Pyles Sutter & Verville
1501 M Street, N.W., 7th Floor
Washington, D.C. 20005

Dear Mr. Thomas:

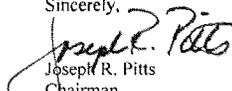
Thank you for appearing before the Subcommittee on Health on Wednesday, May 21, 2014, to testify at the hearing entitled "Keeping the Promise: Site of Service Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Wednesday, June 25, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515 and emailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



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INTRODUCTION

My name is Peter Thomas and I help coordinate the CPR which is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with disabilities, injuries or chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the National Multiple Sclerosis Society, the Center for Medicare Advocacy, the Brain Injury Association of America, United Spinal Association, and the Christopher and Dana Reeve Foundation.

RESPONSES TO QUESTIONS FOR THE RECORD

(ALL QUESTIONS ASKED BY CHAIRMAN PITTS)

Q: In your testimony, you state that data collection from all Post-Acute Care reform sites is an integral step toward balanced and appropriate bundling of services in the Medicare program. I agree that data collection is important but understand that sometimes data collection from different sectors can be impeded by different industries using different proprietary tools that may not all measure the same. In your opinion, how important would the use of a standardized tool by the Medicare program be in our efforts to collect standardized data from the various Post-Acute Care settings?

A: Creating a uniform quality assessment instrument to measure outcomes across PAC settings is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients. Uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTACH CARE instrument for



LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies, are all appropriate measurement tools for each of these settings. But they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute care episode of care.

Q: You state in your testimony that you do not support Congressional efforts to reform Post-Acute Care at this time until data collection and quality metrics are in place to achieve good patient outcomes and until such time, would support the Secretary of Health and Human Services to implement a skeletal PAC bundling plan. What in your opinion would a "skeletal PAC bundling plan" look like?

A: Unfortunately, this question represents a misreading of my testimony. CPR does not, in fact, support passage of any bundled payment system until such time as appropriate quality metric and risk adjusters are ready for implementation. A bundled PAC payment system that includes critical beneficiary protections does not currently exist and, we expect, will take several years to develop, adequately test, and validate. CPR has strong concerns about the development of a skeletal bundling plan prior to the development and establishment of a universal assessment instrument, beneficiary protections against stinting on care, and robust quality measures which include quality of life measures that are meaningful to individuals with disabilities and chronic conditions.

Until sufficient patient protections and a uniform assessment tool are in place, we do **not** support legislating broad PAC bundling reforms (what I referred to in previous testimony as a "skeletal PAC bundling system") that lock-in federal savings and defer to the HHS Secretary to implement all the details of a comprehensive PAC bundling plan. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a number of improvements we would like to suggest to improve the draft BACPAC Act of 2014, including the following:

1. **PAC Bundle Holder:** We have serious concerns with the proposal to permit acute care hospitals and insurance companies to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of rehabilitation to divert patients to the least costly PAC setting. In the absence of robust quality metrics, the only real incentive will be to keep the patient from being readmitted to the acute care hospital which will eventually lead to financial penalties. In terms of quality of care, this is a very low bar. Current law requires the Centers for Medicare and Medicaid Services (CMS) to pilot test a concept known as the Continuing Care Hospital (CCH),¹ where the PAC bundle is held by a combination of post-acute care providers (i.e., LTACH, IRF and hospital-based SNF). This would, at least, place the bundle in the hands of providers who understand rehabilitation and these patients' needs. At the very least, we would suggest the removal of insurers as being eligible to hold the bundle. This would be akin to joining a managed care plan (for purposes of PAC services) within the fee-for-service Medicare program. If beneficiaries wish to join Medicare Advantage, that option is certainly available to them, but this concept should not be permitted to apply to fee-for-service. In any event, the bundle holder MUST

¹ Inexplicably, CMS has not yet pursued the mandated CCH pilot program.



be accountable for the achievement of quality and outcome measures to protect against underservice.

2. **Entities Able to Assume the Risk:** Any bundle holder must be truly able to assume the risk of holding this bundled payment while providing services to a beneficiary across an episode of care, whether it be 90 days or some other time period. Financial solvency and related standards should be explicitly adopted in the legislation to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards ought to be tailored to PAC/rehabilitation providers, such as the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) and other appropriate accreditors.
3. **PAC Bundle Coordinator:** The draft BACPAC bill defines a “PAC Physician” as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the health care professional making treatment decisions be a clinician rather than a layperson, but the bill should require this physician to have experience in post-acute care/rehabilitation service delivery, as this is the very expertise necessary to develop and implement PAC treatment plans.
4. **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle:** CPR believes that certain devices and related services should be exempt from the bundled PAC payment system, just as outpatient rehabilitation therapy and other services are treated under the draft bill. For instance, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period. Prosthetic limbs and orthotic braces are critical to the health and full function of people with limb loss and other disabling conditions. Custom mobility devices² and Speech Generating Devices (SGDs) serve the individual needs of very specific patients under the Medicare program. Under a bundled payment system, there are strong financial incentives to delay or deny entirely access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

This phenomenon was witnessed when Congress implemented prospective payment for skilled nursing facilities (“SNFs”) in 1997 and initially included orthotics and prosthetics in the SNF bundle or “PPS.”³ As a result, most skilled nursing facilities began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of O&P treatment. During this period, patients experienced inappropriate and unreasonable delays in access to O&P care that often make the difference between independent function and life in a nursing home. In

² Custom mobility devices are often referred to as “Complex Rehabilitative Technology” or “CRT.” In fact, bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, “Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013,” H.R. 942 and S. 948

³ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414–22 (1997) (codified at 42 U.S.C. § 1395yy).



1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,⁴ thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.⁵ As a result, SNF patients once again had access to prosthetic care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we recommend that Congress exempt prosthetics, custom orthotics, and custom durable medical equipment from any PAC bundling legislation.

Q: CMS in recent months has taken steps to drastically alter the landscape of the Medicare Part D program by removing protections for critically ill patients as it relates to mental illness drugs and personalized drug plans. It was only bipartisan Congressional and public push back that stalled the effort this month but CMS has insisted that despite such outcry, it plans to go forward with such policies in the future. How can we ensure that CMS or HHS puts in place a system that takes into account your concerns when they have lately appeared so tone-deaf to the concerns of Medicare beneficiaries?

A: CPR does not normally take positions on Medicare Part D policy. However, as a co-chair of the Consortium for Citizens with Disabilities' (CCD) Health Task Force, I can say that many within the disability community are extremely concerned with actions by CMS that threaten the six protected classes of drugs under Medicare. Members of CCD (a national coalition of over 100 consumer and provider disability organizations) actively oppose any action by CMS to lift these protections. One way Congress could ensure that access to Part D drugs is protected is to remove CMS' discretion to shrink or restrict which drugs are protected under this statutory protection.

Q: Medicare is facing insolvency, which would jeopardize care for millions of seniors that depend on the program. What policies or payment reforms would you recommend Congress consider to help keep the promise to seniors by saving Medicare from insolvency?

A: CPR supports Medicare delivery reforms that improve access to quality care for Medicare beneficiaries. Some of the recent programs which have shown that they can, when implemented appropriately, improve the quality of care and produce savings for the Medicare program by enhancing the independence of Medicare beneficiaries, improving health outcomes, preventing secondary conditions and avoiding costly institutionalizations include the Independence at Home ("IAH") program and the Programs of All-Inclusive Care for the Elderly (PACE). These programs should be expanded significantly in the future. Congress should also encourage in the strongest terms CMS to implement the Continuing Care Hospital (CCH) demonstration, which has already been authorized and which would help test post-acute care bundling reforms that could save Medicare money and improve the quality of care in the PAC realm. Congress should also encourage CMS to limit Medicare coverage for orthotic and prosthetic services to those services provided by licensed and appropriately credentialed O&P practitioners and suppliers. To achieve this, Congress should pass the Medicare

⁴ Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325-26 (1999) (codified at 42 U.S.C § 1395yy(e)).

⁵ Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.



Orthotic and Prosthetic Improvement Act, H.R. 3112. Congress should also pass legislation that separates complex rehabilitation technology (“CRT”) from traditional durable medical equipment under Medicare. This bill is known as Ensuring Access to Complex Rehabilitation Technology Act, H.R. 942. Establishing a CRT category separate from DME would make it possible for CMS to tailor coverage policies for individuals with significant long-term disabilities and chronic conditions, ensuring access to the technology that will enhance independence, improve health outcomes and save money for Medicare in the long term by preventing secondary conditions, hospitalizations and institutionalization. Finally, Congress should continue to pass policies which shrink and ultimately eliminate the institutional bias in Medicaid which impacts not only Medicaid beneficiaries, but dual eligibles as well. Programs like the Money Follows the Person (“MFP”) program and the Rebalancing incentives program support transitioning dual eligibles out of institutions and into their homes and communities - the preferred setting of most beneficiaries and the less expensive setting most of the time.

Q: What do you think about the possible savings to beneficiaries if Congress were to combine the A/B cost-sharing and adopt a catastrophic cap? This reform has been recommended by MedPAC, former Sen. Lieberman, and the President's Fiscal Commission.

A: CPR has not taken a position on this proposal. In general, however, CPR opposes policies that produce savings by simply cost-shifting to Medicare beneficiaries. Proposals which shift costs to beneficiaries could very well lower utilization, but they disproportionately hurt those who have severe disabilities and chronic conditions – those who most need health care interventions and who have less alternatives to those interventions. It is possible that combining cost-sharing under Medicare Part A and B could result in cost-shifting, depending on how the policy is implemented.