

**“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  
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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](mailto:bgage@brookings.edu) if you would like to reach me.

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