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MEDICARE POST-ACUTE CARE DELIVERY AND OPTIONS TO IMPROVE IT

THURSDAY, APRIL 16, 2015

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Butterfield, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Also Present: Representative McKinley

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Staff Present: Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Robert Horne, Professional Staff Member, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; John Stone, Counsel, Health; Josh Trent, Professional Staff Member, Health; Traci Vitek, HHS Detailee, Health; Ziky Ababiya, Minority Policy Analyst; Jen Berenholz, Minority Chief Clerk; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; and Arielle Woronoff, Minority Health Counsel.

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Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Over the past several years, this committee has focused on understanding and responding to the need to modernize Medicare's financing and payment structures. Today's hearing will give members and stakeholders an opportunity to examine the current state of post-acute care, PAC, for Medicare beneficiaries and discuss ways it can be improved.

Post-acute care is care that is provided to individuals who need additional help recuperating from an acute illness or serious medical procedure usually after discharge from hospital care. Post-acute care providers such as skilled nursing facilities, SNFs, inpatient rehabilitation facilities, IRFs, long-term care hospitals, home health agencies, and hospices are reimbursed by Medicare with different payment systems, which were originally designed to focus on a phase of a patient's illness in a specific site of service. As a result, payments across post-acute care settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

According to the Medicare Payment Advisory Commission, MedPAC, Medicare's payments to PAC providers totaled \$59 billion in the year 2013. For patients who are hospitalized for exacerbations of chronic conditions, such as congestive heart failure, Medicare spends nearly as much on post-acute care and readmissions in the first 30 days after

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a patient is discharged as it does for the initial hospital admission. Medicare payments for post-acute care have grown faster than most other categories of spending. For example, total Medicare spending for patients hospitalized with myocardial infarction, congestive heart failure, or hip fracture grew by 1.5 to 2 percent each year between 1994 and 2009, while spending on post-acute care for those patients grew by 4 1/2 to 8 1/2 percent per year.

There are many opportunities for the Medicare program to save taxpayer dollars and improve seniors' quality of care through better management of post-acute care. One way is to make sure patients are treated in the most cost effective clinically appropriate setting. The current model has significant reimbursement disparities for treating the same condition. For example, for patients hospitalized with congestive heart failure in 2008, Medicare paid about \$2,500 in the 30 days after discharge for each patient who received home health care as compared with \$10,700 for those admitted to a SNF and \$15,000 for those cared for in a rehabilitation hospital.

Our colleague, Representative Dave McKinley, has had a long interest in this subject and has sponsored legislation, along with Representatives Tom Price, John McNeerney and Anna Eshoo to provide bundled payments for post-acute care services under Medicare. His bill is H.R. 1458, the quote, "Bundling and Coordinating Post-Acute Care Act of 2015" and is also known as BACPAC Act of 2015. This bill is designed to foster the delivery of high-quality, post-acute care

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services in the most cost effective manner while preserving the ability of patients, with guidance from their physician, to select their preferred provider of post-acute care services. This is the type of legislation that has the potential to promote healthy competition among PAC providers on the basis of quality, cost, accountability, and customer service while advancing innovation in care coordination, medication management, and hospitalization avoidance.

I am pleased the committee is examining post-acute care issues. Proposals such as BACPAC have potential to reward quality, achieve savings, and strengthen the sustainability of the Medicare program.

I look forward to hearing from our witnesses today, and I yield back.

[The prepared statement of Mr. Pitts follows:]

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Mr. Pitts. And at this time, I recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for opening statement.

Mr. Green. Thank you, Mr. Chairman.

Millions of Medicare beneficiaries require continued care in post-acute settings after hospitalization. In 2013, 42 percent of Medicare beneficiaries discharged from the hospital went to post-acute care settings. Medicare spent \$59 billion on these services that year. Medicare pays each type of PAC facility at a different rate. These different rates are created under the notion that sicker patients will require more costly care in specialized facilities, which seems normal.

However, advancements in the practice of medicine as well and thoughtful analysis by MedPAC and other independent researchers call into question the wisdom of such differentiated payment rates. MedPAC has long noted that shortcomings in Medicare's fee-for-service payments for post-acute care. Just last month, MedPAC reiterated that payments for post-acute care are too generous and significant shortcomings in the current structure exists. There is broad consensus on the need for improved quality measures across the post-acute care setting and a need for a more coordinated approach to care.

Unfortunately, our current system is characterized by silos. Patient-centered coordinated care is not encouraged by the incentive structure. Yet while there is agreement on the need to improve the

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way post-acute care is delivered and reimbursed, significant challenges have hindered meaningful reform. This includes a lack of uniform definitions, standardized assessment information across care settings, and substantial geographic variation. Progress has been made to address these challenges, including changes passed in the law as part of the Affordable Care Act, the IMPACT Act, and most recently H.R. 2, the Medicare Access and CHIP Reauthorization Act. The Affordable Care Act included improvements in the post-care system, acute care system. As a result, Medicare is currently piloting delivery reforms.

The Centers on Medicare and Medicaid Services is in the process of testing the concept of bundled payments for post-acute care. Bundled payments encourage accountability for cost and quality by incentivizing only clinically necessary care and enhanced coordination. This has the potential to encourage more efficient delivery, break down those silos, and facilitate care coordination.

The ACA also required home health prospective payment system to be rebased to reflect more accurate factors, such as the average cost of providing care and the mix of intensity of services. Rebased is currently being phased in and scheduled to be fully implemented by 2017. These important steps will help move us to an improved post-acute care system for beneficiaries and taxpayers.

Last Congress, the Improved Medicare Post-Acute Care Transformation or IMPACT Act was signed into law. This legislation

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reflected bipartisan, bicameral, stakeholder agreement that meaningful reform must be based on standardized post-acute assessment data also provider settings.

The collection of common post-acute patient assessment data is to determine the right setting for patients who will facilitate discussions on how to reform and improve care for beneficiaries and the Medicare system as large. Without standardized patient assessment data, reforms to base post-acute care reimbursements on patient characteristics rather than on service in setting specific payment rates will be obstructed. There is a widespread agreement that new payment and delivery sent models are necessary to improve our healthcare system and achieve better patient outcomes, population health, and lower per capita cost.

As providers and CMS are in the process of testing new models, there is there is still much work to do. This work is ongoing and now is the time to dedicate resources toward building the knowledge base to help our understanding and inform decisionmaking. There are many potential policies available to pursue and using the lessons learned from recent efforts is an important step. This must be done before considering large-scale adoption of reform. Simply bundling payments in advance of this work would be premature.

The Bundling and Coordination Post-Acute Act, BACPAC, takes a different approach from what MedPAC has considered. Commenting on any specific approach would preempt the results of pilots and preclude CMS

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from utilizing the lessons learned from IMPACT Act and pilot programs to create more effective bundle programs -- models.

I look forward to hearing our witnesses today and further debate on our post-acute care reform. And I yield back my time.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. Now recognize the vice chairman of the subcommittee, the gentleman from Kentucky, Mr. Guthrie for 5 minutes for an opening statement.

Mr. Guthrie. Thank you, Mr. Chairman. I would like to yield my time to our colleague on the full committee, Mr. McKinley from West Virginia.

Mr. Pitts. The gentleman is recognized.

Ms. McKinley. Well, thank you. Thank you, Congressman. And thank you, Chairman, for the opportunity to address the group today.

This legislative hearing on post-acute care and especially on H.R. 1458, this Bundling and Post-Acute Care Act. As many of you may be aware of, this is -- but the President has already put post-acute care bundling in his budget, and we passed it, and the House has already included in our House version of what is in the conference right now is a concept of this. So it is very important that we -- it is not a new concept. It is one that we have been working together on this framework for now 3 years, both with all the stakeholders. We have been working with the committee staff and they have been incredibly supportive in trying to put together something that answers this need. But for 3 years been trying to put this -- because this is going to improve care for seniors and is going to help Medicare in the long run with it.

It develops a model for post-acute care services which will increase efficiency, encourage more choice and personalized care for

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patients, and offer some significant savings to the program in the process. There have been some people have argued that it might cost money. To the contrary. The CBO has already issued a finding that it could save between \$20 and \$25 billion, with a B, for Medicare if this program were put through. Not through cuts, but through creating efficiency in the post-acute care system. A bill that innovates, improves efficiency, protects Medicare and has a pay for of \$20 to \$25 billion, I think it deserves meaningful consideration.

And I really applaud the committee and the chairman all for giving it consideration here today. And I yield back the balance of my time.

Mr. Pitts. Thank you.

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

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. McKinley follows:]

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Mr. Pitts. Now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for opening statement.

Mr. Pallone. Thank you, Mr. Chairman, for calling today's hearing on post-acute care delivery, and I want to thank all of our witnesses for coming to testify, but especially welcome Dr. Steven Landers from New Jersey who is the president and CEO of the Visiting Nurse Association Health Group.

The Affordable Care Act has put Medicare on a path towards post-acute reform. However, there is still 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, long-term care hospitals, or inpatient rehab facilities.

In 2013, Medicare spent about \$59 billion on post-acute care providers, and I believe that there are viable payment solutions in this sector that are more sensible than increasing costs for beneficiaries of average incomes of only \$22,500. What we know is that the quality outcomes and costs of post-acute care has a lot of variation around the country. And as a result of the ACA, Medicare is currently testing a number of payment system reforms that help improve care and outcomes in this area. Meanwhile, the need for post-acute care is not

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well-defined. Research has shown the similarity of patients treated in different post-acute care settings. A patient being rehabilitated from a stroke or hip replacement can be treated in a skilled nursing facility or an inpatient rehab facility, but in the latter Medicare pays 40 to 50 percent higher than it pays the skilled nursing facility for the same services.

And we do not have any common and comparable data across PAC providers to determine which patients fare best in which settings or even what appropriate levels of care are for patients of various acuity. That is why last year Congress passed the bipartisan IMPACT Act which, for the first time, requires providers to report standardized assessment data across the various post-acute care settings. While there are many interesting policy ideas in this arena, we need to learn from the ACA efforts underway and the data being collected as a result of the IMPACT Act and provide enough time to ensure the models work in a way that doesn't compromise access to high-quality services for our beneficiaries.

Data collected by the IMPACT Act, coupled with MedPAC's recommendations that Congress could do better or could better align post-acute care incentives to better utilize Medicare dollars, should be a useful guide for our efforts. And once we have improved information on post-acute care, I look forward to working with my colleagues on the committee to find policy solutions to ensure that Medicare continues to provide quality and effective health care to our

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seniors.

I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman as always.

[The prepared statement of Mr. Pallone follows:]

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Mr. Pitts. Any written statements of the members' opening statements will be made part of the record. That concludes our opening statements.

[The information follows:]

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Mr. Pitts. I have a UC request. I would like to submit the following documents for the record. First, testimony from the Coalition to Preserve Rehabilitation and Orthotic and Prosthetic Alliance, and statements from the National Association For Home Care and Hospice, the Premiere Healthcare Alliance, the American Hospital Association, the American Medical Rehabilitation Providers Association, National Long-Term Hospitals, and the National Association of Chain Drugstores.

Mr. Green. No objection.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Mr. Pitts. We have two panels today before us. On our first panel we have Dr. Mark Miller, executive director of the Medicare Payment Advisory Commission. Thank you very much, Dr. Miller, for coming today. Your written testimony will be made part of the record. You will have 5 minutes to summarize. And, at this time, you are recognized for 5 minutes for your opening statement.

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

Mr. Miller. Chairman Pitts --

Mr. Pitts. Microphone. Yeah. Okay.

Mr. Miller. Sorry about that.

Chairman Pitts, Ranking Member Green, distinguished committee members, thank you for asking the Medicare Payment Advisory Commission to testify today. As you know, MedPAC was created by the Congress to advise it on Medicare, and today we were asked here to talk about our work on post-acute care.

The commission's work in all instances is guided by three principles: How you assure that the beneficiary gets the access to high quality coordinated care, to protect the taxpayer dollar, and to pay plans and providers in a way to achieve those two goals. Post-acute care services are a vital part of the Medicare benefit. They provide rehabilitation and nursing services at critical points in a

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beneficiary's care. But I think we are all aware that there are problems, particularly in fee-for-service, that face the post-acute care.

Our siloed payment systems encourage fragmented care by paying based on setting rather than based on the needs of the beneficiary. The nature of fee-for-service reimbursement itself, encourages service following in which, in some cases, may be unnecessary. We know that if Medicare payment rates are set too high or constructed inconsistently across setting, they can result in patient selection and patterns of care that focus on revenue rather than on patient need. And for post-acute care, the clinical guidelines themselves regarding when services are needed are poorly defined. And this isn't an accusation. This is what happens -- this is what you get when you talk to clinicians and it makes it hard for both clinicians and policymakers in this area to make policy.

So what is the commission's guidance? In the short run, the commission would set fee-for-service payment rates to reflect the efficient provider. For example, the commission's annual payment analysis has determined that payment rates for home health and skilled nursing facilities have been set too high for over a decade, and we have repeatedly recommended rebasing those rates downward to be more consistent with the cost of an efficient provider.

A commission goal is to pay the same for similar patients regardless of setting of care. For example, the commission

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recommended that the secretary examine paying the same base rates in inpatient rehab facilities and skilled nursing facilities for a selected set of conditions where patients appear to be similar, in other words, to have a site neutral payment.

The commission would reform payments to avoid patient selection strategies. We have recommended that CMS revise its home health and its skilled nursing facility payment systems to remove the strong incentive to take physical rehab patients and to avoid complex medical patients.

The commission has recommended policies to moderate excessive services. For example, the most rapid growth in the home health sector is utilization unrelated to a hospitalization. The commission has recommended a modest copayment for those episodes that don't follow hospitalization, and we have published data showing that there are areas of the country with excessively high utilization of home health services and encourage the secretary to use their fraud and abuse authorities to examine those areas.

The commission has also created policies that overlay fee-for-service and try to encourage coordination. For example, we have recommended readmission policy -- or readmission penalties for hospitals, skilled nursing facilities, and home health agencies that exhibit excessive readmission patterns.

We have also made longer run recommendations to create incentives to avoid unnecessary volume and to encourage collaboration across

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various PAC -- the various post-acute care providers, the commission has called on CMS to create and examine various bundling payment strategies to assess patient need, to track a patient's quality of care, and to eliminate the various payment systems for the post-acute care sector and instead have a single unified payment system. For many years, we called for a unified patient assessment instrument. Through the past efforts on the part of the CMS and as the result of the recent passage of the IMPACT Act, that work appears to be underway, but there is still a lot of work to be done here and all of us will need to be attentive to that process.

Beyond traditional fee-for-service, a well-functioning managed care program and initiatives like accountable care organizations can also create incentives to avoid unnecessary volume and encourage coordination, and the Commission has provided a range of guidance in those areas as well.

In closing, the Commission has consistently made unanimous policy recommendations to move away from a siloed payment and delivery system that undermines care coordination and instead move towards one that is focused on the beneficiary and on care coordination, but at a price the taxpayer can afford.

I look forward to your questions.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Miller follows:]

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Mr. Pitts. I will begin the questioning. Recognize myself 5 minutes for that purpose.

Dr. Miller, there have been concerns raised from the home health industry that current legislative reductions in reimbursements threaten the ability of home health agencies to treat Medicare patients. In support of these arguments, they point to cost reports and other data from -- that show profit margins that are either very low or, in some instances, negative. I think everyone wants to ensure the benefit and access to it remains strong.

Have you or your staff looked into this issue? And, if so, what have you found and do you have any recommendations for this committee?

Mr. Miller. We have looked into it and we have reported out on it for many years. Just to be very clear, at the front end of this answer, for many years, we have documented very high profit margins on Medicare patients in home health, in the 12, 13 percent range. And we stand by those numbers just to be very direct in responding to your question.

We are the ones who made the recommendations to start to rebase the rates, and those -- there is a rebasing provision in law. We believe that rebasing provision doesn't go far enough. So I want to be clear about that. And I can take that on further question.

But then I think what may be -- your question may be about and what other people see is numbers like 13 percent margins for Medicare, and then the home health folks will show you a margin that is 2 or 3

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percent. And let me just talk you through that. One thing that you should keep in mind is that the home health industry itself acknowledges that their margins on Medicare are as high as we say. If there are differences there, they are differences of a matter of a few points. So if you listen in on calls with their Wall Street investors and that type of thing, they acknowledge that the margins in Medicare are very high and that that is the place that, you know, a business model or a line of business that they want to attract.

The lower profit margin that you see reported involves a few things. Number one, it can involve other lines of business. So if an organization owns a home health line of business but owns a different line of business, the margin will reflect that. It can reflect lower payment rates in Medicaid and private payers, which often do pay less than Medicare and so their margins will be lower there. It can also reflect costs that Medicare doesn't recognize as allowable, such as political contributions or taxes paid in localities. So I think some of the differences between those two numbers are those types of things.

Mr. Pitts. As post-acute care providers look to innovate in their delivery model, I know that telemedicine is an issue many are focused on. In fact, it is a very important issue at our 21st Century cures discussion. And a number of members are working in a bipartisan fashion to advance the use of these technologies in the Medicare program. However, I have heard concerns that if telemedicine is not done correctly, it could lead to higher expenditures under the program

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without a similar increase in quality or service. What are your thoughts on that?

Mr. Miller. Our view on -- I believe our view on telemedicine is that it can be a useful tool that providers -- and not just home health providers -- can use in order to manage a patient's care and cut down on some of the overhead expense of a face-to-face type of visit.

Our view here is, is that there is nothing in the -- in the payment scheme for Medicare that prevents a home health agency from using this service. And to the extent that the service makes good sense and helps them coordinate care and reduce their cost, they should be allowed -- they should be able to use that service.

I have heard -- and this might be part of your question -- in other settings, people have been concerned that the use of telemedicine, depending on how it is paid for -- and it really does matter how it is paid for -- it does make it easier to generate a visit or an encounter, if you will, and that unless it is monitored, can produce payments per click, if you will, that can result in higher cost. But depending on how it is paid in home health within an episode, I am not quite sure that that problem is present.

Mr. Pitts. Well, Dr. Miller, I just wanted to personally thank you and your staff for the support you have given to this committee to its members on the issue of telemedicine. We would appreciate that continued support as we go forward. And I thank you.

And I now recognize the ranking member of the subcommittee,

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Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Dr. Miller, I too -- and we appreciate your thoughtful examination of the post-acute care payment reforms that MedPAC has done to date.

From your testimony, it appears that the Commission has given some initial consideration of bundled payment design elements such as the scope of service covered, the time span of the care episode, and the ways to ensure quality. And there are tradeoffs between increasing opportunities for care coordination and requiring providers to accept greater risk beyond the care they furnish. As you noted, bundled payments can encourage accountability for cost and quality across the spectrum of care by incentivizing the provision of only clinically necessary and coordinated care.

A recent legislative proposal of the Bundling Act, the BACPAC, seems to take a different approach than what MedPAC has considered. In fact, BACPAC bundle assumes a third-party entity, a coordinator, that would pay PAC providers. BACPAC would also bundle post-acute care services after a patient's discharge from an acute care hospital. Conversely, MedPAC has explored global payments that would cover initial hospitalization and potentially avoidable readmissions in PAC services within the 90 days. So you are going not only from the hospital, but also to the PAC issue.

Could you discuss the pros and cons of the two different

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approaches, I guess?

Mr. Miller. What I want to be clear in commenting on, MedPAC as an organization -- and because we serve the various committees of Congress, won't -- I won't be making any comments pro or con on any piece of legislation.

Mr. Green. Okay.

Mr. Miller. So my comments here will be about what we have done on bundling and what we think about bundling. Hopefully, none of this should be taken as either supporting or opposing a specific piece of legislation.

Mr. Green. Okay. Well, my next question, then, wouldn't a coordinator simply add another layer of payment to the policy?

Mr. Miller. That would depend entirely on, you know, how the coordinator is defined. So if the coordinator is one of the providers within the PAC continuum, no. If it is another provider outside of that continuum, that is decidedly a different actor. Whether it adds cost or not depends on where the money comes to pay for that coordinator whether it is paid out of savings or whether it is paid out of new dollars.

Mr. Green. Well, and that's the next question.

But, Should Congress limit the flexibility in designing what elements of care can be bundled?

Mr. Miller. So, I think -- I think the way I would answer that is the Commission -- just to be clear, the Commission has looked at

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a number of different ways of structuring bundling -- or bundle. So whether it is attached to post-acute -- or acute care and post-acute care, whether it is a set payment that goes to a particular entity or whether, in fact, you sort of draw a circle or a boundary around an episode and then continue to pay on a fee for service, we have talked through those and we have talked through the pros and cons of all of those.

There is, I think, a need to be thinking about these different issues, but I also think that there is a point -- there is a point at which there will probably be some action required by Congress in order to move the bundling concept along. I think that in the past, looking at different ways either through demonstrations in different models have not always produced crisp and timely results for people to act on.

I do want to also say -- well, I will stop there.

Mr. Green. Well, you had mentioned to the chairman's -- a response to the chairman's questions about MedPAC has noted a number of times that post-acute care providers enjoy high margins and obviously investors notice that.

Could you talk briefly about the margins that post-acute care providers receive for Medicare payments and what this tells about the Medicare's payment for these services and if you have recommendations on how Congress should address these high margins?

Mr. Miller. So, and -- and again I am just going to do this at

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a very kind of high-glide level. You are probably talking currently about margins that are in the, you know, let's call it 12 percent range for home health and skilled nursing facilities. Again, these are Medicare margins. You are probably in the 7 range for inpatient rehab facilities, maybe the 5 to 6 range or 6 range for long-term care hospitals. I am not sure I have that as wired in my head.

The Commission's view on these -- and so, for example, in our current -- our most recent March 2015 report, we recommended no update for inpatient rehab facilities and long-term care hospitals, the argument being that they can cover any increase in their input costs with the current level of funding that they are getting. And then for home health and skilled nursing facilities, we have recommended actual reductions in the rate to bring them closer to the cost of an efficient provider.

Mr. Green. Okay. Thank you Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you, Mr. Chairman. And thank you, Dr. Miller, for being here.

In your testimony, you mention that different post-acute care settings treat similar patients, but Medicare pays them different rates depending on the setting. Can you explain why this happens and how much authority CMS has to fix it compared with what is in the statute?

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Mr. Miller. Yeah. I am probably going to be less helpful on the statute and what authority they have. That just may not be something I am as wired on.

Mr. Guthrie. Okay.

Mr. Miller. And again, I want to point out here that some of this is -- you know, the program sets these payment systems up at different points in time. I think that a post-acute care environment is a difficult environment for clinicians to operate in. It is just -- it is a complicated sets of decisions that have to be made.

But, you know, if somebody comes out for -- let's say, out of the hospital for a given procedure, a hip replacement, let's say, depending on the circumstances of the patient, they could end up in an inpatient rehab facility. They could end up in a skilled nursing facility. They could end up in entirely a home health, you know, treatment plan. Medicare would pay differently in those different settings. And what we have begun to see -- and we have seen this both on the acute care side, which we are not talking about today, and on the post-acute care side, places where we feel like we are beginning to identify overlaps of patients and we end up paying very differently for similar patients.

Now, I want to express some caution here. In the post-acute care setting, we have entered this area and we have begun to talk about what we think are similar sets of patients based on our research between the inpatient rehab setting and the skilled nursing facility setting. But by no means are we making very broad blanket statements that you

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can just pay the same in all of those settings. And I also want to say to, at least, one opening statement, some of the information that we get out of the IMPACT Act and the more consistent assessment of patients across settings will help to understand that problem better.

Mr. Guthrie. Okay. And you also stated that the Commission has frequently observed that Medicare's payments for post-acute care are too high and its payment systems have shortcomings. Why do you believe the payments are too high and what are the system shortcomings?

Mr. Miller. Okay. Some of the -- why are the payments too high? Okay. Let me take that part. And then you said shortcoming.

Mr. Guthrie. And shortcomings in this payment systems.

Mr. Miller. Okay. So why are they too high? I think a couple of things go on. And by the way, some of this is good. It is just not the payment system necessarily keeping up.

So let's take home health, for example. So when the home health prospective payment system was created, there was this decision to create an episode, okay. So you had an episode of care. At that point in time, 31 visits on average were provided during that episode of time and the -- a payment system was based on that.

Over time, the home health -- the provision of health care in that episode has changed a lot. There is now about 21 visits provided. Now, in fairness, these visits are more skilled than the visits that used to be provided, you know, when there were 31. But even after you adjust for that, basically what it means is, is that the original base

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rate was set wrong. The industry responded, lowered their -- you know, the way that they were providing care and some of that overhead -- some of that margin was created. You can also see -- so, I think that is one of the issues.

Some of the shortcomings, I think, was another part of your question.

Mr. Guthrie. Yeah. Right. On the payment systems.

Mr. Miller. It is some of these things that we have already touched on here, the fact that you have such different payments in different settings and that clearly sets signals for providers who might say, well, there may be some advantage to go in one direction or another direction. I mean, those are some of the shortcomings.

I also think that there is a difficulty in, at least, in some of the payment systems, a clear signal to provide additional services and there is not a really good way, at least presently, to have a handle to counteract --

Mr. Guthrie. And I got real -- just a couple of seconds.

Mr. Miller. Sorry about that.

Mr. Guthrie. But the Commission, you said, you examined -- in your statement, you said the Commission studied out -- difference in outcomes in SNFs and IFR settings but couldn't compare risk adjusted across that. Was there a reason why you couldn't do the risk adjustment?

Mr. Miller. Okay. So really quickly because I see we are out

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of time here. In thinking about trying to set a base payment that is equal between skilled nursing facility and SNFs, we looked at risk scores, we looked at complications in comorbidities, we looked at functional statuses as best as possible and zeroed in on a few conditions that we think are very similar in the two settings.

One thing that is difficult -- and this is why the IMPACT Act is so important -- is what you really want in a perfect world is the same assessment applied to each patient so then you can truly across settings say, this patient is different than this patient and it is done on a common basis. That is not going on now.

Mr. Guthrie. Okay. Thank you. I yield back.

Mr. Miller. Sorry about the time.

Mr. Pitts. The chair thanks you. Gentlemen now recognizes the ranking member for the full subcommittee, Mr. Pallone, 5 minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman. And I thank you for having this hearing because I think it is very important.

But, Dr. Miller, I was very impressed with the statements you have made so far because you really have been kind of urging caution in terms of how we proceed. And you have also talked about, you know, getting more information from the IMPACT Act, which is what I would like to see before we, you know, move ahead with any particular legislation.

You know, I am just going to use an example with my dad. My dad is 91. He has been in and out of hospitals many times and, I guess,

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my fear in listing -- in hearing some of the statements that have been made about, you know, having a PAC coordinator, you know, who is somehow going to benefit, either he or those who he services are going to benefit from some sort of, you know, pay back if -- depending on, you know, where the patient is placed and this idea of a -- just a 4 percent cut overall. I mean, these things concern me a great deal.

I mean, let me just give you an example. Many times when my father has come out of the hospital, you know, for whatever reason, you know, we have to make a decision -- I say "we," I mean collectively my brother, my father, myself -- about where to place him. And that may be that he goes home and he gets home health care, or he goes and gets home health care for a few weeks and then he goes to the outpatient rehab facility or he may go to a inpatient rehab hospital, or he may go to a nursing home. It has often been a combination of those things, depending on, you know, what he was in the hospital for and what we think as a family is the best way to deal with that post-acute care.

And a lot of times, you know, those are individual decisions because there is great variation. You know, sometimes we don't like the inpatient hospital because we don't think they do a good job or we don't like the nursing home, you know, that has been proposed because we think it is not a very good nursing home. And I would hate to think that those decisions would be made by some coordinator, you know, that I understand you would have input into. But, you know, I would be very concerned that those decisions are being made by some, you know, third

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party who -- you know, who has some sort of financial incentive to make that decision.

So I just think that we have got to be extremely careful with these things because there is such great variation, not only in terms of, you know, nursing home versus home health or, you know, nursing home versus inpatient hospital, but the individual places. In my opinion, whether I think the nursing home or the inpatient rehab facility is better than one or the other has more to do with it than it does about whether I go to a nursing home, per se.

So, let me just ask you some questions about IMPACT. Given that the Medicare program spent \$59 billion on post-acute care in 2013, I am amazed we don't have better information about patient outcome service user quality of care, and it is my understanding that the IMPACT Act will address some of these information shortfalls. You want to comment a little more on that? Does IMPACT think the data gathered as a result of the IMPACT Act will be enough to move us forward? Does Congress need to do more to gather this information? And what is your general feeling about whether we should be getting more information before we make decisions about bundling or cutting Medicare payments?

Mr. Miller. Okay. Let me -- you said a lot in there.

Mr. Pallone. I know. I can spend the whole day on this because it is -- you know, I deal with it every day. I am going to be dealing with it in an hour -- as soon as I leave this hearing.

Mr. Miller. I know. I have a father, I have an aunt that I am

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managing. I know exactly what you are up to.

So, let me try and do this rationally. First of all -- because there are a couple of things I do want to comment on. First of all, you know, the Commission for many years was calling for something like what happened in the IMPACT Act and moved to a common assessment instrument. And we do think that the common assessment instrument and what goes on in the IMPACT Act -- again, we haven't precisely seen what will come out of that. The legislation has set things in process and things will have to be defined in regulation. But we do think that it will do a lot of good in terms of having common domains, having common assessment scales and definitions and timeframes and, you know, the list could go on. I don't want to say it is perfect -- we haven't seen exactly what will come out of it -- and that there is nothing else that will be needed.

But in this area -- and this is a point that I would make -- I think like many things in life and in Medicare, there is movement with caution, but movement. Because the other thing that I would just, by matter of degree say back, is if we wait for everything, you know, all the demonstrations to be finished, all the incentives to be produced in perfection, we won't move forward. And that has happened in the past. And I think the Commission believed there is some ability to move forward with caution.

And here is the kinds of cautions I would say. Things like being sure that you have a transition built in so that the providers and the

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beneficiaries can respond. Be sure -- and to some points that you were making about your own circumstances, that the person who -- because, you know, one thing about a person who thinks about the entire episode, they can -- if well motivated, can actually help the family make those decisions. Because I have stood in the hospital, too, had somebody say here is a list, make up your mind, what do you want to do? And you don't have a lot of sense of what to do.

Mr. Guthrie. [Presiding.] Thank you, Doctor. This is all, I mean, very good. And I appreciate what you are doing, but we are going to try to get some questions in before votes.

Mr. Miller. All right.

Mr. Guthrie. So I appreciate that.

Mr. Miller. Sorry I took so long.

Mr. Guthrie. And you did -- it is a great discussion.

Mr. Shimkus from Illinois is recognized.

Mr. Shimkus. Well, that is okay, because I am very curious about the response and some of my questions were involved with that. Because, I think, following up on Mr. Pallone's questions, sometimes, in essence -- I don't know the right terminology -- but an advocate or someone else who could give some advice on the options from a practical application. I mean, the challenge is you are given a list, pick one, and you don't have anybody to help you through that.

So, I am on the flip side. I am not sure that it costs more. I think it may save more in time, effort, energy, and frustrations, with

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more information as someone who is doing that on a day -- someone who is doing that on a day-to-day basis.

I think the challenge of folks our age with older adults is that we don't have the experience, and then we get thrown into it based upon an event and we are still juggling our lives, too. So, do you want to -- and you were going to answer and going to follow-up on that so go ahead.

Mr. Miller. So I don't want to cause, you know, a nuclear reaction here --

Mr. Shimkus. Oh, this is the Energy and Commerce Committee. We like that.

Mr. Miller. You are both right. Okay. And, I mean, I think the concern Mr. Pallone was mentioning is, is you don't want somebody making that decision too aggressively --

Mr. Shimkus. Right.

Mr. Miller. -- for the wrong reasons to save money. But on the other hand, if you can structure the payment system in such a way that -- if you can structure the payment system in such a way and you have risk adjusted carefully for the differences in the patient, you have quality metrics so that if a person chooses to stint in order to save, then that is a problem. So you want this person who is giving the guidance to have motivation to make sure that the person gets the highest quality care and, also, not to -- and to avoid unnecessary services.

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I think both of you can be right on this matter, but you don't want to tip too far --

Mr. Shimkus. No. And I understand that.

Mr. Miller. -- in one way or the other.

Mr. Shimkus. And I appreciate that.

The other part of the questions that we have had before is about necessary data, how long do you wait before you start moving forward. What data do you think is necessary and needed for additional reform before additional reforms are adopted? So what data is not out there that you think you need to have?

Mr. Miller. Well, here is what I would say. First of all, again, I want to say that the Commission, you know, had lots of pushing for many years on what ultimately ended up in the IMPACT Act. We think it is a good start. And so a lot of that information should be helpful. And just because I am probably not loaded enough to give you what data we are missing, I would say this: The other thing we can be thinking about is there are sets of recommendations that we have made that we can do now, that don't involve bundling, which is not to be -- disparage bundling at all. And you can think of less aggressive versions of bundling to start moving the providers in that direction.

So think of the notion of saying I am going to define an episode of care. I am going to continue to pay on a fee-for-service basis and there is various mechanisms you can put in place to be sure that you don't overpay, and then the providers are beginning to move to the

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bundle concept without actually having a hard, in-place, here-is-the-boundaries, here-is-the-payment kind of bundle. And I would encourage that because that will produce information as well.

Mr. Shimkus. So let me follow. I mean, you are right. It is like we choreographed this a little bit, so -- which we did not --

Mr. Miller. We did not.

Mr. Shimkus. -- for the record.

Mr. Miller. I have never seen you before.

Mr. Shimkus. So -- but how should CMS or Congress, then, accomplish the recommendation of this? I mean, so you are saying we should, so how should we or CMS?

Mr. Miller. Yeah. So, I mean, the kinds of things, I think, the Commission would say is you should keep work going on looking at bundling and more of the, you know, the structure types of approaches to bundling that, I think, some people are talking about, but at the same time also be thinking about mechanisms that begin to bring providers together. Some of them are more rudimentary, such as saying, you know, if there is a lot of readmissions here across this set of providers, all of you are going to feel an effect. And so you are not saying you are in a bundle, you are not being paid by a single entity. But, if my actions result in a readmission, you and I are both going to feel it. Those types of things, and we have recommended on that front.

And then the other thought that I am trying to get across -- but

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I am not sure I am doing it particularly well -- is begin to say to that set of actors, I am now going to start looking -- I am making this up -- we are now going to look at what happens over 60 days in a totality type of way and if you, in terms of outcomes and payments, if you do well or do poorly, your payments will be affected that way. In a sense, it is like injecting the ACO or the Accountable Care Organization concept --

Mr. Shimkus. Right. Right.

Mr. Miller. -- into more of the episode concept, if you will. Sorry if I took too much time.

Mr. Shimkus. No. Good.

Mr. Guthrie. Thank you. The chair now recognizes Dr. Schrader from -- or Dr. Schrader from Oregon for 5 minutes for questions.

Mr. Schrader. Thank you, Mr. Chairman. Appreciate that. You know, I do some of this post-acute care myself, but I am a veterinarian. So it is a little easier to do that way.

Along those lines, I guess, a question I have -- looking at the IMPACT Act reviewing, I mean, that is a long-term project potentially and, you know, I am not sure we want to wait until 2024 whenever all that is done.

Is there some earlier date by which the committee or Congress should be informed by some of the information we are gleaning that you think would give us an opportunity to move forward in a very thoughtful way on this bundle payments thing?

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Mr. Miller. Yeah. Unfortunately, we have a couple of mandated reports as a result of the IMPACT Act, and one of them is on a very short timeframe, and so hopefully we can give you some sense there, out of that report.

Mr. Schrader. And what is that timeframe again?

Mr. Miller. Next summer, I am disappointed to say.

Mr. Schrader. Next summer. Okay. Okay. And then you have been talking about margins quite a bit. How are you calculating those margins? In other words, if I go to my skilled nursing facility or rehab group, are they going to agree with your assessment of the margins out there?

Mr. Miller. No, they are not --

Mr. Schrader. And why would that be?

Mr. Miller. -- to answer your direct question.

Actually -- I'm sorry. I shouldn't be facetious. I don't think our margins are mysterious at all. They come out of the Medicare cost reports that your skilled nursing facility or whomever else, home health agency, fills out. There are rules about what costs and how they are allocated, and then we calculate the cost and then we calculate the payments that a facility --

Mr. Schrader. And how is theirs going to be different? You know, when they are calculating their margins, how are they going to be different than what the model you are using?

Mr. Miller. Well, what home health and the skilled -- well, what

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the skilled nursing facility argument goes like this. This is the most common argument, okay. We recognize that Medicare margins are in the range that MedPAC says, 11 or 12 percent, but Medicaid and the private sector are paying us less. We are not earning as much money there. Our margins are much lower and, I think, the total margin is something like in a 2 percent range there. And then they say, you should pay more because you are basically cross-subsidizing these other payers.

The Commission's position on that is you are the Congress of the United States, you control the pursestrings, you can decide how dollars are allocated, but you should be clearly conscious that what you are doing is saying, this Medicare dollar is now subsidizing dollars in the States or in the private sector and we think that that is, you know, at least a big question that should be faced head on.

Mr. Schrader. All right. In the ACA, there were some demonstration projects on bundled payments and that, you know, it included, not just acute care, but some of the skilled nursing. You indicated, I think, that that was kind of a token. What are we learning from that, if anything, and if --

Mr. Miller. Right.

Mr. Schrader. -- it is not giving us the information we want, what should we be asking to get from what we are doing hopefully in the near future?

Mr. Miller. Yeah. And the second part of your question -- or this question I probably want to think about a little bit more. But

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what I guess I am concerned about -- and you did pick up on this. So, for example, in the bundling demonstration, there were many thousands of actors who said, "I am interested in understanding, you know, my experience in bundling." And then it comes to the second phase that says and "How many of you would be willing to take risk?" And that becomes -- drops immediately to the hundreds, okay, or even the 100.

Then it says, "Which of the conditions are you willing to be at risk for?" And that comes to two or three. And so, in a sense, you had, "I am really interested in looking at this." How much risk would you be -- would you be willing to take risk and then for what? And then you are down to relatively small numbers. And my concern -- and I think the Commission's concern -- is this process isn't going to produce a very clear set of models and a clear set of generalities to say, okay, here is the direction to go.

And I think what the Commission needs to do is, given that environment, try and bring you guys -- the committees of jurisdiction some structure in order to say what do you do if that information doesn't arrive in a very crisp and clear way.

Mr. Schrader. Real quick. And you may not be able to answer it in time. But it seems like with the Accountable Care Organizations or, in my State, the Coordinated Care Organizations, they are willing to take a lot of risk. Can't they deal with the bundled payments also for post-acute care as well as acute care? Do we need another organization or outfit to do this?

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Mr. Miller. This is a really -- this is a really good question. And part of the reason the Commission on the bundling front -- I am going to answer this in the time. Well, apparently not.

But either way, this is a really good question because the Commission has two different views on this. Some people say -- and not just the Commission -- why not move to more of a population-based model, like an Accountable Care Organization, and then maybe the episodes continue as a payment mechanism in those, but maybe they are superseded by the fact that you actually have a population model management.

Mr. Schrader. Yeah. Okay. Thank you.

And I yield back.

Mr. Guthrie. Thank you. Gentleman yields back.

The chair recognizes Dr. Murphy from Pennsylvania for 5 minutes.

Mr. Murphy. Thank you. Welcome, Dr. Miller. It is good to have you here.

What MedPAC has looked at and what we are talking about here are patients with a similar clinical condition receiving similar treatments from different providers at different locations for different costs. Am I correct?

Okay. So has MedPAC ever looked at the issue of patients in a different way, the same clinical conditions, receiving the same treatment from the same provider at the same location for different costs?

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If you would like to -- I can give you a little more details. Would you like some more details first?

Mr. Miller. Yeah. I am not sure I -- I am definitely trying to hear you.

Mr. Murphy. Okay. I put anecdotally about cases where a patient received, for example, chemotherapy from a physician that was billed as a physician-based practice.

Mr. Miller. Okay.

Mr. Murphy. And then that same patient was seen by the same doctor, for the same treatment, at the same location and was billed as hospital outpatient treatment at an incredible markup price after that office became part of a larger healthcare system. Are you familiar with that?

Mr. Miller. Oh, yeah.

Mr. Murphy. How widespread is this practice?

Mr. Miller. Okay. We have looked -- we have looked at this. I can't give you just a flat out number, here is how widespread this is. However, we have looked at specific sets of services, not the one you have raised, but specific sets of services and seen the shift in billing basically from the physician office stream to the outpatient stream and it is, as you describe. I am going to the same physician office I went to, I am seeing the same set of physicians, I am seeing -- getting the same service and now the bill is being run through a different payment system, the outpatient hospital payment system, because the

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hospital has acquired the practice and the markups can be very -- or the payment increases can be very high and, of course, the beneficiary's copayment goes up commensurately with that.

Mr. Murphy. Precisely.

Mr. Miller. We made two recommendations in this area on sets of services that we identified, and they met certain criteria which I won't take you through because of time and all of that. Because, again, we wanted to be careful that we didn't undercut the hospital's mission, but at the same time this particular phenomenon, we felt, was not good for the taxpayer, not good for the beneficiary particularly when we are talking about the same service, same provider.

Mr. Murphy. Sure. So we have heard examples, for example, where someone was getting oncology treatment, chemotherapy, that, in one instance, may cost \$10,000. When the hospital acquires the practice, it is billed at \$30,000.

Mr. Miller. I am -- yes.

Mr. Murphy. We have heard similar things for a dermatological procedure, et cetera. And then a person's copay may have a several thousand dollar difference as well. So it currently is legal. Am I correct?

Mr. Miller. Yeah.

Mr. Murphy. Is it ethical?

Mr. Miller. The Commission has raised great concerns with this practice.

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Mr. Murphy. Do you wonder if it is ethical?

Mr. Miller. Say it again.

Mr. Murphy. Is it ethical that someone has found this loophole and is --

Mr. Miller. I will speak only for myself, not the 17 commissioners, okay. No. I see this as a problem.

Mr. Murphy. Thank you.

So, previous MedPAC analysis has shown that hospital-based reimbursements is much higher, as we said, and paying the doctor more than a nonhospital affiliated facility.

Mr. Miller. I'm sorry. Would you --

Mr. Murphy. Sure. I have a cold, and so it is hard for me to --

Mr. Miller. I apologize.

Mr. Murphy. That is okay. I am sick. But what am I going to do? See a doctor?

Mr. Miller. And I am a little nervous.

Mr. Murphy. Anyways.

So I am paying the doctor more and charging a senior more for same service at a nonhospital affiliated facility. Can you comment on what degree a similar dynamic is differentiated payments? You may be operating in the post-acute space and its relationship to costs for seniors and potential consolidation of treatment facilities similar to those we have seen in the cancer setting.

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RPTR KERR

EDTR HUMKE

[11:15 a.m.]

Mr. Miller. I now do understand what you are saying, and often the beneficiary difference in the post-acute care setting is not as extreme as you see in the acute care setting. So in the acute care setting when somebody -- and this is why, when you asked your very pointed question, I see problems here. You know, the beneficiary is paying 20 percent of whatever happens, as a general rule.

In the post-acute care setting, it is a little bit murkier. So let's take -- and actually it may not be as much of an issue for the beneficiary. Let's take the inpatient rehab facility and the skilled nursing facility. The beneficiaries generally retire their inpatient admission deductible and they go to these facilities. Unless they stay for long periods of times, they don't necessarily have a copayment that goes along with it. So the circumstances are actually just a little bit more -- a little less -- they are not as consistent as you see on the acute care side.

Mr. Murphy. Okay. Thank you. I know I am out of time, but I just hope we continue to work with you to get more information on that process I spoke about, what those net costs may be costing Medicare as well as seniors with copays. I am sure as you go through this -- and Mr. Chairman, I hope we can get that information and report that back.

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Mr. Guthrie. [Presiding.] Thank you. The gentleman's time is expired. Let me -- we are really pushing votes. Let me recognize the gentlelady from California, Ms. Matsui.

Ms. Matsui. Thank you, Mr. Chairman. And Dr. Miller, thank you very much for your testimony. This is somewhat similar but not really talking about hospitals here to Dr. Murphy's questions.

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 care. Whether a patient goes to a home health agency or a skilled nursing facility, for example, seems to depend more on the availability of the post-acute care settings and their local market, patient and family preferences or financial relationships between providers.

Now, putting aside what Dr. Murphy was concerned about, and I think we all should be concerned about that, but if we proactively look at this, since patients and also, too, the hospitals have a role in this because they don't want the readmittance either, so look at that, too, but since patients often access post-acute 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?

Mr. Miller. Okay. I think there is a couple of things to say here. Number 1, there is, I think, one of the reasons the Commission said there should be -- and part of the problem of making a bad referral

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is, is that the patient had some complication or bed sore or something and bounces back.

Ms. Matsui. Right.

Mr. Miller. And so one of the reasons that the Commission, I think, took this position of the hospital, the skilled nursing facility, and the home health should all feel a readmissions penalty if a readmission occurs, is to try and build in -- you know, the hospital needs to be conscious of it but also the hospital's partners --

Ms. Matsui. Partners.

Mr. Miller. -- or implicit partners should be conscious as well to try and militate against that.

A second thing that goes -- a second thing that goes on is there is something called the Medicare spending payment per beneficiary. This is a very arcane thing, but it is buried deep in the value-based performance metrics that hospitals are judged by, and so to the extent that that has some impact on their payment, they are paying attention to the 30 days that followed the discharge. But there again, if you are a hospital, you sort of say, you are holding me responsible, but there is all these other actors, how do we bring them into it.

And that is what gets us to some of the things that we are discussing today, whether you start thinking about payments affects that cut across like what I will call loose bundles or hard bundles, depending on what kind of model we are talking about, and then of course the level above that is if there is an accountable care organization

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that the hospital is a part of --

Ms. Matsui. Right.

Mr. Miller. -- then obviously it has those incentives kind of built into that.

Ms. Matsui. So we are taking those steps now to have the responsibility sort of be more than implicit in a sense.

Mr. Miller. I think there is still steps to be taken, but absolutely. So, for example, the Congress has implemented readmission penalties for hospitals and skilled nursing facilities but not home health.

Ms. Matsui. Exactly.

Mr. Miller. My understanding is home health and the skilled nursing facility, or -- you know, associations and environments agree that there should be readmission penalties. The details --

Ms. Matsui. The devil is in the detail.

Mr. Miller. -- we probably disagree on but that would be usual.

And then there are -- I also want you to know this. And actually the whole committee to know this. There are discussions in the Commission. These are very -- I mean, it is public. It is in the transcript, so it is -- but we haven't jelled on it of, should there be some greater steering on the part of the hospital if the provider is being steered to have high quality rankings, that type.

Ms. Matsui. That is what I was --

Mr. Miller. I kind of thought you were going there.

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Ms. Matsui. Yeah, going toward. I have a -- quickly, another question. What about those beneficiaries that access post-acute care without a hospital stay?

Mr. Miller. I mean, there is something of a different ballgame there.

Ms. Matsui. Yeah.

Mr. Miller. The community admits are sometime -- the words there. There is something of a different ballgame there in the sense of that beneficiary, it's potentially more difficult for the program to figure out whether we have a needed service there because the person doing the admitting -- I don't want to overstate this, but the person doing the admitting in some instances is the person who is going to benefit from the admission in terms of the provider.

Now, you can be referred by community physicians, of course, but there are also, you know, decisions made by the particular provider to take a person in to continue to add episodes of care, for example, in a home health setting.

Ms. Matsui. Okay.

Mr. Miller. And so I think some of the things we might need to think about there is whether the beneficiary bears some small portion of the cost so that the decision is not just completely open-ended to the beneficiary.

Ms. Matsui. Sure.

Mr. Miller. And whether there needs to be some ability to look

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at prior authorization, that type of thing.

Ms. Matsui. Okay. Well, thank you very much, Dr. Miller. My time is up. Thank you.

Mr. Guthrie. Thank you. The gentlelady yields. Be advised we are in votes now, so we will probably be able to get to one more 5-minute set of questions. Then we will reconvene following votes, probably about 12:15 we walk off the floor.

Mr. Griffith, from Virginia.

Mr. Griffith. Thanks. And I will try to be brief.

And I am going to go off on a little bit of a tangent. When I was in the Virginia State legislature and then subsequent to that, North Carolina, adopted zoning requirements that would allow med cottages to be placed in somebody's back yard if a member of their family had medical needs that required two or more procedures a day. And the estimates were that this would save a lot of money. Of course, it is not paid for by the Federal Government at this time.

And I would just ask that you all look into it because the concept is, is that you would build a hospital room in a mobile facility -- basically the mobile home manufacturers love the bill for that reason because they would get this, but it would allow somebody like myself, if I were to suddenly have a major problem to stay in with my loved ones. And we had testimony in Virginia at the time that there was a young man who was 8 or 9 years old who was dying and his parents wanted to be with him, but they couldn't get a medically appropriate

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place for him in his rural community, and so the parents had to both quit their jobs and spend the last few months with him in a hospital room in Charlottesville, Virginia.

I think this is a concept that both saves money and is compassionate. It helps patients stay with their loved ones if they can, not necessarily in the hospital, but where they can have some treatment brought to the home where that is possible, in lieu of having a nursing home bed perhaps, but with the number of nursing home folks shouldn't be too opposed to it, and weren't at the time, because they see the market expanding so much that this niche would be there.

Just ask you to think about it. I think it is something for the future, and I would appreciate it if you all would take a look at this concept and be happy to give you any information that you need.

Mr. Miller. Okay. I appreciate that.

Mr. Griffith. And with that, Mr. Chairman, and many questions already having been asked and answered, I yield back.

Mr. Guthrie. Thank you. Yield back. And since you yield back some time, I am going to recognize the gentlelady from Florida, Ms. Castor.

Ms. Castor. Thank you, Mr. Chairman.

Dr. Miller, whenever we are talking about payment reform, I am always concerned that we are appropriately accounting for the complexities and differences among patients. I believe that if we move forward to reform in the post-acute care setting, we should be looking

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to make sure that we appropriately adjust provider payments to reflect beneficiary risk. Every -- and personal conditions, and it kind of follows on what Mr. Guthrie was asking about.

Could you give us a -- quickly, a little greater detail, do you believe a risk adjustment is an appropriate issue to focus on and what steps do we need to take, for example, in developing a bundled payment that would appropriately account for differences in beneficiaries?

Mr. Miller. I do think it is an incredibly important point. I think -- and regardless of what kind of payment system we are talking about, you need to get the risk -- you need to get risk adjustment so that -- straight so that providers don't have an incentive to avoid the most complex patients. And a lot of our work has been focused on that in different settings of trying to adjust the risk and the payment systems to fix those very kinds of problems. And so you do need it.

I think again, the data that will come through the IMPACT Act will help, but we are not completely without, you know, abilities to do that now. And one -- I want to say one other thing before I say that. The other thing you want to do to help mitigate risk is have quality metrics so that if you really don't treat a patient well, the signal comes back through your payment, and then also you can do it through insurance functions, things like this.

It is an episode payment, but if you have an outlier, then there will be a payment that comes in behind that. So that the person realizes a patient is going south or potentially could go south, they

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aren't completely exposed to that. And that also helps them make more willing to take the complicated patient.

So all -- I think, in answering your question, risk, absolutely important, don't forget -- and I know you haven't -- but you know, quality feeds into that, and then an insurance structure in addition to that like an outlier payment all helps try and mitigate the concern which I think is you don't want them avoiding the most complicated patients. And I think there are bundles of mechanisms you can kind of think about. Anyway, I will stop.

Ms. Castor. Thank you.

Mr. Guthrie. Thank you. The gentlelady yields back. And I believe we concluded the questions for the first panel, but the committee will recess, and once we recess, we will reconvene following the last vote, and we will commence with the second panel at that -- we will begin with the second panel at that time. The committee is in recess until call of the chair after the final vote.

[Recess.]

Mr. Pitts. [Presiding.] Ladies and gentlemen, if you will take your seats, we will get started. Thank you very much for your patience with the vote, and then before that, I had to duck out for the signing, the enrollment ceremony for the SGR which is a nice little celebration.

So, we are back now with the second panel, and I will introduce them in the order that they speak. Dr. Steven Landers, president and CEO of the Visiting Nurse Association Health Group, Dr. Samuel

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Hammerman, chief medical officer of the LTACH Hospital Division at Select Medical Corporation, Dr. Melissa Morley, program manager of health care financing and payment at FTI International, and Mr. Leonard Russ, principal partner at Bayberry Health Care and chairman of the American Health Care Association.

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

And we will begin with you, Dr. Landers. You are recognized for 5 minutes for your opening statement.

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**STATEMENTS OF DR. STEVEN LANDERS, MPH, PRESIDENT AND CEO, VISITING NURSE ASSOCIATION HEALTH GROUP; DR. SAMUEL HAMMERMAN, CHIEF MEDICAL OFFICER, LTACH HOSPITAL DIVISION, SELECT MEDICAL CORPORATION; MELISSA MORLEY, PH.D., PROGRAM MANAGER, HEALTH CARE FINANCING AND PAYMENT, RTI INTERNATIONAL; AND MR. LEONARD RUSS, PRINCIPLE PARTNER, BAYBERRY HEALTH CARE, CHAIRMAN OF AMERICAN HEALTH CARE ASSOCIATION**

**STATEMENT OF DR. STEVEN LANDERS**

Dr. Landers. Thank you, Chairman Pitts, Mr. Shrader. Thank you, Mr. McKinley for your leadership on this issue and honored to be here with my home State Representative Pallone.

Today's hearing is timely and needed. Seniors are being discharged from America's hospitals and finding themselves often in a poorly coordinated and costly post-acute care continuum. Sometimes instead of order, there is disarray. Instead of teamwork and clear care paths across venues, there is fragmentation and confusion. Instead of efficiency, unnecessary costs are being borne by patients in the Medicare program.

My organization, VNA Health Group, serves some of the oldest and frailest Medicare beneficiaries. As a result, we have seen firsthand how bewildering and burdensome the current situation can be for ailing seniors and their families. I think of an example, Patient Mrs. Smith,

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an 82-year old woman with arthritis, congestive heart failure, and low vision, being discharged from a hospital where she had recently been treated for a broken hip caused by a fall. She has received some information but is still in pain and sleepy, and she and her family aren't sure of what to do. Her daughter, her main care giver, isn't sure who is going to be in charge after she is discharged and who to go to with questions.

Mrs. Smith and people like her have some basic but important needs, including a comprehensive and holistic assessment of her post-hospital needs and circumstances, help accessing the care that she needs that is right for her condition, the support of a cadre of professionals like nurses and therapists and social workers and physicians, short-term assistance with activities of daily living and basic living nutrition. Her story is not atypical. People like her are being discharged from hospitals each day across our country. They are our parents, our grandparents, aunts and uncles, and soon they may be us.

If Mrs. Smith and seniors like her receive the coordinated care that they need, they will recuperate more quickly at a lower cost with lower risk of rehospitalization, but too often this isn't the case, and people aren't getting this type of care. Older Americans like Mrs. Smith don't have what they need most, which is patient-centered care coordination. This means true -- having a partner that is truly invested in helping them get better soon, a physician and nursing team by their side across care venues, integrated electronic information

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systems that will help avoid adverse events.

We believe that patient-centered care coordination can be achieved through PAC bundling that adapts a successful DRG model and provides consistent coordination and navigation support to discharge beneficiaries and their families. It is for this reason that the Partnership for Home Health -- for Quality Home Health is proud to support the BACPAC Act. The BACPAC model incorporates elements that we feel are important to patient-centered care coordination. A model on diagnostic related groups, which have been in use for over 30 years, creates condition related groups to align interests and improve outcomes, ensures patient choice, network adequacy, and the use of clinical and technological innovations to improve care. It uses powerful risk and saving incentives to prioritize high quality coordinated care, and it strengthens program integrity because no coordinator is going to want a bad or fraudulent actor to be in its network. It aligns with Congress' passage of the IMPACT Act, which created a unified PAC assessment tool and achieves significant savings without cutting any providers' rates or increase in costs for any seniors.

There are many complex issues to be addressed, and as you do, please keep seniors like Mrs. Smith in mind so that Medicare post-acute care policy will not only be improved but work for the most vulnerable among us. Thank you.

Mr. Pitts. The chair thanks the gentleman.

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[The statement of Mr. Landers follows:]

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Mr. Pitts. Dr. Hammerman, you are recognized for 5 minutes for your opening statement.

**STATEMENT OF DR. SAMUEL HAMMERMAN**

Dr. Hammerman. Good afternoon. Thank you, Chairman Pitts and Ranking Member Green for holding today's hearing on the future of American post-acute care. My name is Dr. Samuel Hammerman. I am the chief medical officer of Select Medical's long-term acute care hospital division. I oversee more than 100 LTACH hospitals in 30 States.

I will try to offer some insights today based on my experiences and based on the experiences of the company I am proud to serve as the chief medical officer for, Select Medical. Select Medical is based outside Harrisburg, Pennsylvania, and is one of the largest providers of post-acute care in the country. Besides the 100-plus LTACH hospitals, Select Medical also operates about 20 inpatient rehabilitation hospitals, and 1,000 outpatient therapy clinics. All together, Select Medical employs over 30,000 Americans in more than 30 States.

Let me begin by saying that Select Medical does not oppose a bundled post-acute payment system. With this in mind, my observations on our post-acute care systems are as follows. I want to stress that Congress has already enacted extensive legislation laying the foundation for bundled payments for post-acute services. Just last

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fall, Congress passed the IMPACT Act of 2014. This law will enable Congress to develop an informed and evidence-based post-acute bundling system. We were happy to support this bipartisan bicameral bill.

The IMPACT Act will provide the Centers For Medicare and Medicaid Services and Congress with the necessary information, design a post-acute care payment system that stresses quality of care while maximizing efficiencies in the delivery of care. I salute Congress for moving to a new system while ensuring continued beneficiary access to the most appropriate setting of care.

On a similar note, I would note that the Affordable Care Act of 2010 established a number of new programs. It has post-acute bundling in hundreds of sites across the country. CMS is currently in the midst of numerous pilot programs testing numerous bundle payment concepts. In short, Congress and CMS have already largely commissioned a bundled future for post-acute care.

As a physician, I feel compelled to note that the current post-acute system still has many virtues. I would still make the case that the post-acute continuum of care represents a fairly logical and rational progression of care. Yes, we need to address the issue of readmissions, and yes, policymakers should always be concerned about whether care is appropriate and medically necessary.

As a historical aside, I ask you to consider that only about 10 percent of Medicare spending is devoted to post-acute care, and please recall how the post-acute sector came into being in the first

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place. In 1983, the Medicare program adopted the first prospective payment system which greatly encouraged hospitals to discharge patients more quickly.

Post-acute, as we know it today, only came into existence because of the incentives to discharge quickly from general hospitals. My advice to Congress is that you try to preserve a range of post-acute providers that offer a range of services from lower acuting nursing homes to higher acuity post-acute hospitals like rehabilitation hospitals and LTACH hospitals. All play a distinct role in meeting the needs of the American patient population.

One public policy issue important to both taxpayers and post-acute providers is ensuring that patients are cared for in the most appropriate setting. We agree that patients who can be safely and effectively cared for in sometimes less costly facilities like nursing homes should not be treated and paid for in rehabilitation hospitals and LTACH hospitals.

Little more than a year ago, Select Medical supported a new law passed by Congress designed to ensure that only appropriate patients are admitted to LTACH hospitals even though the law also significantly reduced Medicare reimbursement for these facilities. My larger point is that post-acute providers will continue to work with Congress to ensure that Medicare cost savings are achieved and beneficiary access to appropriate care is preserved.

Finally, I was asked to comment specifically on Congressman

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McKinley's BACPAC bill. BACPAC has some positive attributes, but it does not address many core elements of a bundled payment system and leaves these to the HHS Secretary to develop. Given the BACPAC's gaps, details on payment rates, a payment process, provider network requirements, a patient assessment process, and quality standards, the BACPAC bill appears to leave a great deal of policy work to CMS. This results in unanswered questions about how BACPAC would actually work in the real world. More importantly, we have concerns about the BACPAC bill because we feel it would shortcut the comprehensive payment reform processes that Congress launched in 2010 under the ACA and built upon in 2014 with the IMPACT Act.

Rather than supporting the IMPACT plan to first test bundling in the marketplace on a small scale, BACPAC would cut short this process. And given the complexity of the issues, this process is needed to develop a reliable and evidenced-based bundled payment program for post-acute care. Thank you.

Mr. Pitts. Thank you.

[The statement of Mr. Hammerman follows:]

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Mr. Pitts. Dr. Morley, you are recognized for 5 minutes for opening statement.

**STATEMENT OF MELISSA MORLEY, PH.D**

Ms. Morley. Chairman Pitts, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to speak with you today. Since 2007, I have worked on several projects with the assistant secretary for planning and evaluation and CMS looking at both the composition of PAC episodes and the potential to predict episode spending using patient assessment data. On the basis of my experience conducting research in this area, I will highlight several relevant findings and note data and analysis required to move this payment approach forward.

The proportions of Medicare beneficiaries discharged to PAC, episode utilization and spending differs significantly across the United States because of varying practice patterns and availability of PAC providers. Differences in provider supply, particularly with regard to long-term care hospitals, LTACHs, and inpatient rehabilitation facilities are key drivers of differences in overall episode spending.

Establishing an episode-based payment requires an understanding of service use and spending on average; however, this is challenging when considering high cost but low-frequency services such as LTCH.

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For example, although only 2 percent of beneficiaries discharged to PAC use LTCH services, the mean cost for those using LTCH is over \$35,000. When this spending is averaged over all PAC users, the mean cost is less than \$700. This demonstrates a challenge in establishing a payment rate that is sufficient to accommodate the range of PAC services.

To build a payment system for PAC episodes that is risk adjusted based on patient characteristics, standardized patient assessment data are critical. However, standardized assessment data are not currently collected across PAC settings. As part of exploratory work with ASPE, we have examined the potential to develop risk adjustment models using items from the CARE data collected as part of the post-acute care payment reform demonstration.

These efforts have demonstrated the potential to use CARE items as risk adjusters to predict episode spending. Results of this work also highlight important differences in the predictive power of the models, depending on the first site of PAC. This foundational work is valuable in demonstrating the potential to use CARE items in an episode-based payment system, but additional data are needed to test the models on larger samples and to examine any differences in significant risk adjusters across diagnosis groups.

With the passage of the IMPACT Act, more data may become available over the next several years, although it is not clear at this time which items will be collected across PAC settings and whether the data that

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will be collected will be sufficient for the purposes of building an episode-based payment system.

Addressing the complexities of an episode-based payment system will require additional analyses as well as consideration of the results of the evaluation of the CMS Bundled Payments for Care Improvement initiative. The BPCI initiative is currently testing whether a bundled payment can reduce cost while maintaining or improving quality of care for Medicare beneficiaries.

The first evaluation report is an early assessment based on one quarter of data; however, results of analyses looking at cost shifting to the post-bundle period, beneficiary outcomes, using assessment data, and beneficiary experience using surveys are expected in future reports. Evaluation results comparing PAC service-only episodes with more integrated episodes that include both the acute hospitalization and PAC services will also provide valuable information on provider incentives across episode definitions.

The foundation of an episode-based payment system is the diagnosis groups on which payments are made. Significant analyses and input from clinicians will be needed to develop the categories of diagnoses and to define unrelated readmissions. Analyses to develop payment adjustments for geography will be important to address differences in provider supply and in cost of care across geographic areas. Consideration of provider networks and resources to support beneficiary choice will also be important.

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Another consideration is related to the establishment of payments for services that continue past the end of an episode period. End-of-episode patient assessment data could not only support any post-episode service payment but also could be valuable information for ensuring quality of care. Episode-based payments offer the opportunity to coordinate across settings to provide care more efficiently and with greater beneficiary focus. The results of the ongoing analyses in the BPCI evaluation as well as availability of national standardized patient assessment data will be very important to moving this payment design forward.

Thank you for the opportunity to speak with you today.

Mr. Pitts. Thank you very much for your testimony.

[The statement of Ms. Morley follows:]

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Mr. Pitts. Mr. Russ, you are recognized 5 minutes for your opening statement.

#### **STATEMENT OF LEONARD RUSS**

Mr. Russ. Well, thank you, Chairman Pitts, and thank you, Ranking Member Green, and members of the committee. I will be speaking somewhat extemporaneously and divert somewhat from my prepared remarks only because I think the testimony as written is in the record.

I would like to say at the outset, I am Len Russ, I am chairman -- or current chairman of the American Health Care Association. We represent nearly 13,000 skilled nursing facilities around the country, serving more than 2 million Medicare beneficiaries each year for short-term stays.

At the same time, our members are also hybrids. We also deal with the long-term population. We are also serving Medicaid patients, and I think, alluding to what was the earlier testimony today, that margin that we constantly focus on, we have to look at the real margins because we are taking care of a hybrid kind of population, all of which fall under the umbrella of our Nation's frail and elderly.

We, as skilled nursing facilities under the Medicare system, are one of the remaining sectors that still are paid basically on a fee-for-service system. The fee-for-service model that we currently enjoy is the prospective payment system. The prospective payment

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system has been in existence now for the better part of more than a decade, and we -- and has been subject to many criticisms, tinkering by CMS, et cetera, for the fact that there has been concern that there was an over-delivery of certain services at the expense of the under-delivery of others.

We at HCA champion the notion of healthcare reform. We believe in payment reform, and we have come up with a proposal ourselves to change payment reform for our sector as possibly a building block towards bundling. We do not believe that this current iteration of bundling is workable. We don't believe that the opening up of the conveners or third-party managers of a bundle will do anything to manage care but more likely just manage payment.

And as we have heard throughout the day, we talked about the, you know, breaking down silos, I think we need to be very mindful that by simply breaking down a payment cycle doesn't necessarily break down the care delivery system. That coordination is not always in line with simply realigning the payment system.

So having said that, we at HCA have come up with basically six principles by which we think any bundling proposal or largely any healthcare reform proposal needs to adhere to. The first is that with any post-acute care sector, the management of that bundle really should have -- really should be left with the providers in the long-term -- in the post-acute care space. So that hospitals, which the BACPAC bill would still allow to be the sort of care coordinator or third-party

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conveners, which might siphon off precious dollars from the payment into their own pocket, so to speak, for allegedly managing the care, whereas they are just managing the dollars, is probably not productive.

We also believe that smaller providers, and our organization represents very large corporations as well as regional companies, independent owners like myself do not have the economic muscle to be able to take on the kind of risk that would be required in order to become a care coordinator. So this is not going to present us with a level playing field.

Secondly, we want to be sure that Medicare beneficiaries have provider choice, and we see that the possibility that these kinds of bundles could raise barriers rather than break down barriers to access care. I also, for example, have five-star facilities, but I am not allowed to join certain networks in managed care right now because they don't necessarily need the access, and there are facilities that are perhaps one-star facilities who are in the network. So the notion that the quality facilities will rise to the top has so far not been borne out.

We also -- you know, so we are not able to possibly join some of the these networks and offer the members choice, and I think any qualified excellent quality provider should be able to have access. We want additional flexibility in rendering care, not with a relaxation of regulations but being less prescriptive with how many minutes of therapy we give, with the venue of the therapy, so that we are measured

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on quality and outcomes.

AHCA has worked collaboratively with CMS and our partners on the Hill to make monumental strides in terms of improving quality over the last several years, both in terms of rehospitalization rates, in terms of reduction of antipsychotic medications, et cetera.

Finally, I just want to say that in any bundled system, we need a virtual bundle, not an actual bundle. A virtual bundle is something where the providers, even if they are aligned in a cohesive spectrum of care, can bill Medicare directly as opposed to leaving it to one provider to hold the dollars and have the others go to those -- to that provider to get paid. It is not necessarily a reliable payment system and it is not necessarily something that can be held accountable in the very, very thin margins and the cash flow stresses in which we operate. So with that, I will --

Mr. Pitts. The chair thanks the gentleman.

[The statement of Mr. Russ follows:]

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Mr. Pitts. I thank all the witnesses for your testimony. I will begin the questioning and recognize myself 5 minutes for that purpose.

Dr. Morley, you state in your testimony that there are geographic differences in the number of beneficiaries discharged post-acute care. Is this exclusively a provider distribution issue or is it a result of regional variation in standards of care?

Ms. Morley. I think it is both. Provider distribution is most clear, particularly using the example of the LTCHs or areas of the country without any access to LTCH providers, and that care is primarily delivered in acute care hospitals and skilled nursing facilities. However, there are also geographic differences in just patterns of care, so it is both factors that are contributing to the variation.

Mr. Pitts. You state in your written testimony that, quote, "additional standardized patient assessment data are needed to test risk-based models on larger samples," end quote. What type of additional data needs to be collected?

Ms. Morley. So the work that we have been doing with ASPE over the last several years has been work based on the post-acute care payment reform demonstration data where care data were collected on about 200 providers across the country between 2008 and 2010. That data has been very useful for developing the framework for a risk adjustor, but we have been unable to look at subpopulations of patient diagnoses and to get a broader national understanding of how these models might differ for patients across the country.

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Mr. Pitts. Dr. Hammerman, what can Congress do to ensure range of post-acute providers, as you state in your written testimony?

Dr. Hammerman. I am sorry, could you repeat that question?

Mr. Pitts. Yeah, what can Congress do to ensure a range of post-acute care providers, as you state in your written testimony?

Dr. Hammerman. So I believe that in a sense, being that the information is being provided via the IMPACT tool, i.e., functional assessments that will be looked at, in addition to the bundling projects that are under way, there will be data to be able to differentiate patients one from another, from the higher acuity patients that we currently manage in the long-term acute care hospital setting, as well as inpatient rehabilitation setting, as well as the lower acuity patients that goes to a skilled setting or cared for in a home environment.

Mr. Pitts. Dr. Landers, in what ways would condition-related groups, or CRGs, align incentives for improved outcomes and reduce cost?

Dr. Landers. The CRG model would create an incentive for the coordinators to look at care across the different venues of care that patients might be in, so that we can focus on having individuals in the most appropriate setting but also the most cost-effective setting, and that should both address quality and cost.

Mr. Pitts. Mr. Russ, in your opinion, do you believe CMS' quality improvement star rating system for PAC providers has improved the

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quality of care in the PAC setting?

Mr. Russ. Well, I wouldn't say that it is -- in and of itself it has improved the quality of care. I think it has made the spectrum of care providers more mindful of certain metrics to adhere to which we agree help measure quality. We think some of those metrics are flawed and not properly risk adjusted, but on the other hand, we are championing quality and working collaboratively with CMS on many of the components of the five-star system and particularly with the component of five-star that deals specifically with the quality measures.

So we believe that, you know, even though the five-star system is not perfect and we probably could come up with a better system, we are not opposed to a system that ranks and measures quality. Indeed, we are championing such a system, and we think such a system also should be an integral part of any kind of post-acute care bundling system that the -- the BACPAC bill, although it has some positive features such as the elimination of a 3-day hospital stay, is a bit short on ensuring quality and accountability across the spectrum, and I think pays more lip service to the notion of care coordination, and it seems to be more focused on payment coordination.

Mr. Pitts. Quickly. What is the difference between your organization's quality initiative and CMS' quality improvement star rating system?

Mr. Russ. Well, our quality initiative is basically focused in

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five main areas, which CMS is mindful of, we have been working collaboratively with. They have adopted several of our quality initiative metrics or variations thereof to include in the five-star system, but we are comprised mainly so far, and we are going into the second generation of that system, so far we are focused on rehospitalization, on the reduction of off-label use of antipsychotic medication, on ensuring staff stability for the sake of continuity of care for the frail and elderly, and also focused on customer satisfaction.

Mr. Pitts. Thank you. My time is concluded. The chair recognizes the ranking member Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Dr. Morley, from Dr. Miller in our first panel, we heard MedPAC's concerns with potential stinting of care under the bundle payment design. The BACPAC Act requires the secretary to ensure that the cost of the bundles do not exceed 96 percent of the PAC expenditures that would have been made. The bill also specifies that PAC providers would pay -- be paid an amount that is not less than the amount which they would otherwise be paid. In other words, the bundles have to reduce cost without cutting provider payments.

It seems to me that savings can be -- only be generated by reducing prices in volume. The legislation, however, does not allow for price reductions; therefore, savings that come from volume reduction are less care. My first question. Could you discuss the dangers of bundles

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incentivizing stinting of the care or what we might do with it or do about it?

Ms. Morley. Yes. I think one of the most important considerations here is the risk for stinting and cost shifting. This is always a concern when setting a prospective payment. So to the extent possible, we want to protect against stinting and cost shifting with strong quality measures. In combination with a payment incentive under a bundled payment, quality measures can incentivize providers to deliver the most appropriate care and to achieve high quality beneficiary outcomes.

Mr. Green. Can you speak about the potential effects of reducing the volume of services that beneficiaries receive?

Ms. Morley. I think, again, back to the stinting and cost shifting. Without strong quality measures, there is an incentive to deliver fewer services in order to maximize the savings over the bundle for the entity holding the bundle, but I do think that with the quality measures in place, there can be -- these incentives can be changed to protect beneficiaries.

Mr. Green. Okay. You also mention that -- your testimony, a potential that services may be required outside the 90-day window established by the BACPAC. Does the BACPAC require PAC coordinators to pay for their services needed after the 90-day period? Since PAC coordinators are on the hook financially for only those services within that 90-day window, is it possible we may delay certain services until

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that window has been ended?

Ms. Morley. To my knowledge, it seems that the PAC coordinators would not be responsible for services after the 90-day period, but it is possible that there would be an incentive to delay services to that post 90-day window unless those quality measures were in place to incent providers otherwise. We know from earlier research that the majority of service used is generally complete by a 90-day period, but there is some service use that does continue after 90 days for -- especially for medically complex patients, so if episodes end and services continue, information may be needed to set payments for those remaining services.

Mr. Green. Okay. The other concern about this is the financial incentive to stand on care and incent the least expensive setting. For example, under the BACPAC, the PAC coordinators would be able to keep most of any savings they achieve. In other words, if a certain episode bundle is \$1,000, the coordinator may spend only 600 on the beneficiary, so there is a \$400 difference. Does this not make this profit contingent on meeting certain minimum quality thresholds?

Ms. Morley. I think that the strong quality measures need to be put in place to reduce stay incentive for cost shifting, stinting and potentially adverse beneficiary outcomes. Some potential quality measures that could be considered would be related to functional outcomes, cognitive status outcomes, or other items related to stint integrity as examples.

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Mr. Green. I guess we need to have those quality controls there because a coordinator could profit from bundling those patients to the least expensive setting as opposed to more clinically appropriate, so there has to be some guidelines there.

So Mr. Chairman, I yield back my time

Mr. Pitts. The chair thanks the gentleman. Now recognize the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you, Mr. Chairman. Thank you all for being here. Sorry we were disrupted in the middle, but we had to go vote.

Dr. Morley, I want to ask you, do you think it is possible to establish episode-based programs while still including long-term care hospitals in the equation?

Ms. Morley. I do, and -- but I think, as I state in my testimony, I think it is going to take a lot of research and understanding of patterns of care, and -- so that there is an understanding that these services are not uniformly available across the country. There will need to be specific geographic market adjustments so that beneficiaries will have access to use the services that they need, but I think it is possible to, you know, to find a way to include all settings.

Mr. Guthrie. Thank you. And also for you, Dr. Morley. What ideas do you have for reforming this space outside of bundled payments? Is that the only option or are there others?

Ms. Morley. I think another option that has been discussed and discussed this morning, as you know, move to site neutral payments.

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That is a way to, you know, to move beneficiaries to thinking -- to move providers to a space where they are thinking about, you know, what care is needed for this beneficiary, kind of regardless of setting, and I think setting neutral payments is separate from bundling but is another approach.

Mr. Guthrie. Thank you. And Dr. Hammerman, do you believe that bundled payments and other types of reforms with the same philosophy have the potential to reduce necessary care -- to reduce necessary care, and if so, what steps would you recommend policymakers to mitigate these concerns?

Dr. Hammerman. Thank you. I think that, in general, the way that the long-term acute care hospital environment evaluates what is available from a bundling perspective, we need to strongly consider that the manifestation from the ICU patient population will continue to grow. The chronically, critically ill patient population will continue to grow, so any bundled strategy that takes effect will have to keep in mind that this patient population will be significant in both the near and long term.

Recommendations are certainly in the realm of looking at these functional assessment tools and making certain that we keep in mind with this catastrophically ill patient population that the first venue is extraordinarily important to move forward because, as we know from the critical literature and as a practicing pulmonary critical care physician, that the return to an ICU from a post-acute setting can

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increase the mortality five- to tenfold, not just 5 to 10 percent. So I think any bundling strategy that we would look at in the future has to keep that in mind from a very strong clinical perspective.

In our opinion, the clinician at the bedside working with the interdisciplinary team has ultimately the largest priority in terms of making certain that we put patients in the right venue at the right time for the right reason.

Mr. Guthrie. Okay. Well, thank you both for your answers, and thank the panel for their testimony, and I yield back my time.

Mr. Pitts. The chair thanks the gentleman. Now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. Capps. Thank you very much. And thank you, Mr. Chairman, for holding this hearing, all of the witnesses for your testimony.

I am pleased that we are here today to discuss post-acute care. I know how important this care is for patients who need continued medical attention. From long-term hospitals to home health providers, the various post-acute care providers all, each discipline offers essential healthcare services. I think we all agree that the way that post-acute care is delivered and paid for needs improvement.

There are many elements that go into making a high quality cost-effective system, and as with any change to Medicare, we must carefully consider the impact a policy change will have on the quality of care and access to care for patients. We must first need -- we first must need to gain a better understanding about how to measure quality

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of care across the different post-acute care settings.

Dr. Hammerman, in your testimony, you point out that the ACA put in place many important stepping stones for PAC, post-acute care reform. Currently, Medicare is testing and advancing a number of payment system reforms for post-acute care, including bundled payments and value-based purchasing.

So my first question to you, Dr. Hammerman, is to ask you to describe some of the bundling demonstrations that have been created under the ACA and what we are learning from them so far. That is just the first of a few questions I have.

Dr. Hammerman. Certainly. I think I can speak in a very limited fashion in terms of from a long-term acute care hospital perspective, not overall in terms of a grander scheme of the BPCI projects. From that perspective, we have limited participation at this point from an LTACH perspective but more of a larger perspective from --

Mrs. Capps. Excuse me, LTACH? Long-term care facility.

Dr. Hammerman. I am sorry. Long-term acute care hospital standpoint.

Mrs. Capps. Oh, got you.

Dr. Hammerman. So we have some experience in that realm, and I am happy to get further data for you offline as well.

Mrs. Capps. Awesome. As a nurse, I am always concerned about how policies that reform payments will affect the quality of care to patients, and demonstrations from the Affordable Care Act are going

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to be crucial to providing some of the information we need to measure quality across PAC providers, but more work is needed, and I look forward to any information you can supply.

My second question has to do with data from the IMPACT Act. While I share the concern of my colleagues that we must address the current challenges with post-acute care payments, it is important to look at the facts and examine the strategy you have already made. When the IMPACT Act was passed in the last Congress with strong bipartisan support, we ensured that post-acute care data could be standardized.

This standardization allows for the comparison of patient assessment data across the various types of providers. Dr. Hammerman, in your testimony, you attested to the ability of this bill to help develop an informed and evidence-based post-acute care bundling system.

Do we have all the data yet that the IMPACT Act might provide? If not, what kind of information might we learn about measuring quality of care in PACs? Or -- and if this is something that you would rather refer to one of your colleagues there, that is fine with me, too.

Dr. Hammerman. Certainly. I can do that. From speaking from the long-term acute care hospital perspective, that data will be and is valuable to the next steps in terms of a bundling strategy, but I am happy to ask one of our colleagues, perhaps Dr. Morley, to comment on the IMPACT Act, or Dr. Landers.

Ms. Morley. I can comment really to the IMPACT Act data. It is

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my understanding that there will be a phase in related to the data collection and that some of the first sets of data for SNF, IRF, and LTCH will be available in 2018 and home health in 2019. I think that, you know, one year of data would be ideal in order to be able to analyze and support the development of a payment system.

Mrs. Capps. Did you want to add one --

Dr. Landers. I would just like to, you know, disagree with the notion that we need more time and a lot more data to begin improving post-acute care. I think that there are a lot of people that are struggling right now with uncoordinated care and there are unnecessary costs, and also I want to point out that the Affordable Care Act and also the recent SGR fix, which incentivizes physicians to enter into alternative payment models, has greatly accelerated the adoption of what are called accountable care organizations or Medicare --

Mrs. Capps. Right.

Dr. Landers. -- savings programs. Across the country right now, as we speak, we are seeing consolidation of health systems, we are seeing people aligned along the strategy of these accountable care organizations, and within them, they are making some pretty aggressive changes to how post-acute care is delivered within those systems. And so some of the same things that people have raised concerns is would there be stinting I think it was called, and would there be inappropriate shifting, that is all happening without the thoughtful structure of something like the clinical related group that has been

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outlined in this law.

So I think that a lot of the things that we are concerned about happening if we move too fast are actually happening in the context of the recent reforms, and this would actually add more protections.

Mrs. Capps. And we need data about them, it seems. I have one more question. I don't know if there are other people waiting to speak.

Mr. Pitts. We have one, but go ahead.

Mrs. Capps. Okay, if you don't mind, extend my time a little bit. But I think we are at a point where, then you are saying, if I may extrapolate from what you said, that we have enough data already, that we can begin organizing and making some changes based on that, not to denigrate from the fact that we probably need more data.

But Mr. Russ, I had a question for you, because my biggest concern is that without the proper information, we risk setting up a new payment system that incentivize providers to cut corners on care. I think it is clear from today that more information is needed as we look at reforming post care, even though, as you say, we have a lot of data about things that are already working and could be.

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RPTR RULL

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[12:55 p.m.]

Mr. Russ. I would simply say that I agree with that premise. I think the initiative that is being taken is to be applauded on many fronts as far as trying to move the modeling forward to create economies of scale and to create efficiencies of care delivery. But I do think that we don't have enough data to go whole-heartedly into a particular system yet where we don't know what the unintended consequences may be.

Mrs. Capps. Right.

Mr. Russ. There are a lot of risks associated with it and we -- at this vital time, this pivotal moment where we are moving away from fee for service and there is a consensus throughout post-acute care and through all the stakeholders and policymakers that we need to move to a better, more effective model, that we don't plunge into something that is not yet well tested and that doesn't have -- not have unintended consequences creating barriers to access of care and to providers participation.

Mrs. Capps. Thank you. Thank you for allowing me to go further.

Mr. Pitts. Sure. Thanks the gentlelady.

And now, without objection, the chair recognizes the prime sponsor of the BACPAC legislation, Mr. McKinley, 5 minutes for

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questions.

Ms. McKinley. Thank you, Mr. Chairman. And thank you to the panel.

It was interesting how the first panel we had, they primarily were interested in cost. I saw a lot of questions had to do with cost, and the second panel you are more interested in -- appropriately in quality of care and how that is going to be but --

So, let me try to address some of the issues I heard in the first panel before we went to vote is about the cost. I just want to remind everyone that I know it differs from the quality, but they need to be reminded again. This is a paid-for program with \$20 to \$25 billion in savings to protect our Medicare system. We also know that there have been at least three test cases of using this, both in Fresno, California and the Midwest and New England that actually have tried this model. And in all cases, the savings have been anywhere from 10 to 21 percent savings. So this thing does work on the cost side of it.

And, Dr. Hammerman, you raise the issue of readmission. And having served on a hospital board for 28 years, I am very sensitive to that. And under this particular legislation, the cost coordinator is the one that is going to be responsible for that. So let's go back to what that -- the definition for those. I am sure everyone has read the bill. But under the provision, it is for the patient with the guidance of their physician, the guidance of their physician, to select

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their preferred provider, this coordinator. And then under the definition of the coordinator, it could be a hospital.

So when we talk about cost cutting here, we talk about cutting quality, we are talking -- you are challenging hospitals that they are not doing quality care because under the very bill, it says they can be the coordinator. It could be a PAC -- the PAC coordinator, insurer, or third-party administrator or a combination of hospital and PAC. So there is a whole series all of -- all of which come down to the secretary will make the determination of how their qualifications are set so they could be selected to be able to provide the services. The bottom line is, we are trying to find ways to help people find through a coordinator to get the best care for them so that they don't get readmitted to the hospital.

So, Dr. Landers, let's go back to your -- it is essential, as we know, that any reform we undertake results in the improvement over the status quo of our rural communities. I come from a rural America, Wheeling, West Virginia. And in many areas all across this country, it is rural.

So we are concerned, do you anticipate that rural patients will benefit from care coordination that is provided under this model; and that the coordinators, these ones that we have described, will have full rural coverage?

Dr. Landers. I think that -- thank you for the question.

I think that, in order to be competitive, the coordinators are

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going to have to have an adequate network and they are going to have to make sure that they have providers available for the provision of services to patients in rural communities. I also would add that because you have preserved the rate and benefit model within the bundles of the current system, things like this effort to improve the rural payment like in home health services in the recent law that those have been preserved, the additional 3 percent to account for their cost, I think that there are safeguards in place to protect rural patients, yes.

Ms. McKinley. One of the things that we have talked often about, I don't -- as the chairman has pointed out, I don't serve on this committee as -- but I am keenly interested in a lot of these issues primarily because of the waste, fraud, and abuse that we hear often used here in Washington about Medicare.

So we look at this thing. And do you think this BACPAC legislation will help weed out some of the bad actors that have perhaps been abusing this system by using a coordinator?

Dr. Landers. Yes. I just can't imagine the coordinator model, where the incentives are aligned for them to, you know, shepherd cost effective and high quality care, that they would engage, you know, fraudulent providers. I think this could be one of the biggest fraud prevention measures ever undertaken.

Ms. McKinley. Thank you. I wanted that to come out.

And then, also, I just spoke on the floor before we came out with

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some of the other people that were in the committee earlier today, and we were talking about some of these issues. And one of the questions that was raised also in the first panel was, is this going to be a cost outside the system, and it is not. And I was explaining that. They hadn't had a chance to review the bill yet, and that was that this is built into the cost. So that we want to reinforce, this is not our projection, but this is from the CBO that says that, under this legislation, it scores between \$10 -- or \$20 and \$25 billion and for -- and it was added that we could very well be addressing some of the waste, fraud, and abuse in the system by virtue of this cleaning out the bad actors.

So I appreciate your panel and the questions raised. I think there is -- there have been some very interesting points. It is a framework. It is going to keep moving. I hope that some of the issues that you have raised can be amended and corrected and added into this legislation. But we have to move forward. I don't think we want to be waiting for another 2 or 3 years before we move on this.

So I thank you, Mr. Chairman, for having this hearing and I hope that we can proceed with this legislation. Thank you.

Mr. Pitts. The chair thanks the gentleman.

Now recognizes the gentleman from California, Mr. Cardenas, for 5 minutes for questions.

Mr. Cardenas. Thank you very much, Mr. Chairman.

Mr. Russ, you are the chair of the American Healthcare

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Association --

Mr. Russ. Yes.

Mr. Cardenas. -- otherwise known as HC -- AHCA. Your organization has developed a new payment concept for skilled nursing facilities to create your own bundle. Your payment proposal promotes patient-centered care and high quality facilities while saving the government money.

Mr. Russ. Yes. If I could elaborate on that, even though that is not the focus of today's hearing, but I think it is part and parcel of the broader discussion about reform.

We have come up -- and we are in the process of finalizing with the help of the Moran Company -- an episodic payment system for our sector. That would take us away from the current fee-for-service prospective payment model. It would make our members assume greater risk for the particular care that they are given, but they would be getting what is essentially a flat payment to cover all of the services rendered under our roof in that post-acute care space in exchange for delivering quality outcomes. There would be penalties presumably associated with failure to deliver quality outcomes, and it would protect against what might be deemed the overdelivery of services now under the current fee-for-service system and yet prevent us from underdelivery of service which might -- some people might argue could take place when a third party convenor or other entity is managing an across-the-spectrum bundle.

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So we think that this is a great step forward for our sector. We don't necessarily think it is the final chapter for our sector, but we think it is the best possible iteration of change that we could muster in a path toward possible broader spectrum post-acute care bundling. It could be a step in that direction, but we really believe it will hold us more accountable. And essential to the whole system is the measurement, empirical measurement, of quality.

Mr. Cardenas. Thank you, Mr. Russ. You testified that your organization has six guiding principles that you use to evaluate PAC bundled payment models and that the BACPAC Act either doesn't meet those principles or is unclear. One of those principles is that the policy must preserve a patient's freedom of choice of provider.

Can you speak a bit more about your specific concerns with the BACPAC Act and preserving freedom of provider choice?

Mr. Russ. Yeah. I think in the larger sense, I mean, when you have got networks that are being established, inevitably there are going to be certain providers, for whatever reason, whether they are judged on quality, whether they are judged on economic expediency, whether they are judged on their ability to provide lower cost to the care coordinator, we don't know what those incentives are going to be, but they are inherently exclusionary. They don't allow all willing, good quality, highly rated by CMS providers to participate.

And while we may pay lip service to the notion that ultimately the patient will decide who the provider will be whom they are going

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to access services from, ultimately, the care coordinator is going to make that decision because they are coordinating the bundle. And so I don't necessarily see how this will enhance patient choice. I think it would probably reduce patient choice, and I think it would also reduce the ability of any willing good provider to participate in that particular bundle.

Mr. Cardenas. So, is AHCA concerned that there is no mechanism for a beneficiary to seek PAC outside of their coordinator's network without switching to a new coordinator?

Mr. Russ. Well, you know, I think there are so many ambiguities in the bill as to how this would roll out. I think our overarching conclusion is that this doesn't seem to be practicable or implementable. And I think when you consider also the various demographic differences across the country -- we have heard a lot about rural settings. There are urban settings. There are settings -- each marketplace is driven differently by who happens to be the powerhouse in that marketplace, whether it is a hospital network, whether it is a home health agency, or whether it is, you know, a large string of skilled nursing facilities. You have got a very, very uneven playing field and a kind of, you know, nebulously conceived bundle payment package to, you know, overlay this is going to be very difficult, if not impossible to implement effectively and consistently across the country.

Mr. Cardenas. Thank you, Mr. Russ.

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Yield back my time. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. That concludes the questions from members who are present. We will have follow-up questions. I know other members who couldn't make it back will have some questions. We will submit those to you in writing. We ask that you please respond promptly.

And I remind members that they have 10 business days to submit questions for the record. Members should submit those questions by the close of business on Thursday, April 30th.

[The information follows:]

\*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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Mr. Pitts. Very good hearing. Thank you very much for the information. Very important. Without objection, subcommittee is adjourned.

[Whereupon, at 1:07 p.m., the subcommittee was adjourned.]