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Testimony
of
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for the
Committee on Ways & Means
of the
U.S. House of Representatives
"After the Hospital: Ensuring Access to Quality Post Acute Care"
March 11, 2025

Chairman Buchanan, Ranking Member Doggett, and members of the Subcommittee, I am Lisa Grabert, a Visiting Research Professor in the College of Nursing at Marquette University in Milwaukee, WI. It is truly an honor to sit on this side of the dias, as I have spent many hours behind you as a former staffer of this, the most powerful Committee in the US Congress. I have dedicated the past 20 years of my career to improving the Medicare program, and I applaud the committee for addressing the important topic of post acute care.

My testimony focuses on: 1) the Improving Medicare Post Acute Care Transformation (IMPACT) Act of 2014, 2) regulatory relief, and 3) transparency within Medicare Advantage.

Current Status of Medicare Post Acute Care

The Medicare program is the largest purchaser of health care services in the US and accounts for nearly a quarter of spending on personal health needs.[1] Over the next decade, Medicare is projected to cost US taxpayers nearly $2 trillion.[1] The Medicare program is an unsustainable path—the Part A or Hospital Insurance Trust Fund is projected to be insolvent in 6 years.[2] One factor driving this cost is spending across the post acute baseline.

On an annual basis, approximately $60 billion in taxpayer dollars are spent to deliver services to Medicare patients in 4 unique post acute care settings.[3-6] In 2022, the Medicare Fee-for-Service program paid $16.1B for home health services, the FFS marginal profit was 23%, and policymakers recommended a 7% payment reduction.[3] $29B was dedicated to nursing homes, the marginal profit was 27%, and policymakers recommended a 3% payment reduction.[4] $8.1B was dedicated to rehabilitation hospitals, the marginal profit was 39%, and policymakers recommended a 5% payment reduction.[5] In 2020, $3.4B was dedicated to long-term care hospitals, the marginal profit was 18%, and policymakers did not recommend a payment reduction.[6] The average FFS Medicare marginal profit across these 4 settings is 27%.[3-6]

Given the status of the Part A Trust Fund, coupled with the excessive Medicare margins, the Committee's focus on post acute care is the exact conversation the Medicare program needs.

Improving Medicare Post Acute Care Transformation (IMPACT) Act of 2014

In 2013, Congress initiated a public, transparent policy process whereby the Chairman and Ranking members of the Ways & Means and Finance Committees posed 64 questions to stakeholders.[7] After multiple rounds of consensus building, the IMPACT Act was signed into law a year later.[8] There were two remarkable things about its passage: 1) it was a stand-alone Medicare bill, meaning it did not ride on the coattails of a larger "must-pass" vehicle; and 2) it was passed via unanimous consent in the House and Senate.[9-10]

The main goal of the IMPACT Act was to establish a unified post acute care prospective payment system or " PAC PPS." Congress mandated a "technical prototype," which means the Centers for Medicare & Medicaid Services (CMS) was to deliver the operational specifications of a payment system that was ready for implementation.[8]

To lend credibility to CMS's ability to implement a unified PAC PPS, the Trump administration included the reform in its fiscal year 2021 budget proposal.[11] The reform would have saved $80 billion in the 10-year budget window if implemented.[12]

To further advance efforts toward a unified PAC PPS, CMS submitted the technical prototype to Congress in 2022.[13] The main finding was that the prototype is capable of Congress's intent toward a unified payment approach for post acute services. Simply put, the unified PAC PPS is ready. **I strongly recommend that Congress give CMS the authority to implement the unified PAC PPS**.

Regulatory Relief

Justifying regulatory relief within post acute care, given the average 27% marginal profit, will be challenging. The IMPACT Act required CMS to "provide recommendations on which Medicare fee-for-service regulations for post-acute care payment systems under title XVIII of the Social Security Act should be altered." [8] Yet, CMS did not include any regulations in its Report to Congress, signaling it could not justify regulatory relief.

A unified PAC PPS may obivate the need for several existing policies, including the home-bound requirement for home health, the three-day inpatient hospital stay requirement for nursing homes, the sixty-percent rule for rehab hospitals, and site-neutral payment criteria for long-term care hospitals.[14-17] In addition, there may also be rules that are appropriate to waive in the interim while the transition to a unified PAC PPS is underway, including counting observation days in an outpatient hospital toward the nursing home 3-day stay, and high acquity criterion for long-term care hospitals, such as the policy recently introduced by Representative Hern.[18]

Congress should only consider regulatory relief in tandem with a unified PAC PPS. These regulatory policies are of high value to the industry-specific providers who receive FFS payments and are likely to add to the deficit. Revenue generated from implementing a non-budget-neutral unified PAC PPS is necessary to offset spending related to regulatory relief.

Transparency of Post-Acute Care within Medicare Advantage

Although we have readily available information about the FFS post acute care margins, we do the Medicare Advantage (MA) margins remain elusive. However, my economic intuition tells me we can reasonably assume post acute providers do not enjoy an average 27% Medicare marginal profit from MA plans. Unlike FFS Medicare, MA plans cannot exert monopsony power over post acute providers during the negotiation process. Empirical evidence supports the spillover of FFS payment rates to MA.[20]

To address the gap in managing post acute care, MA plans may be using other tools in their toolbox, including prior authorization. The Health and Human Services Office of the Inspector General (OIG) found that rehabilitation hospital discharges are among the top services subject to prior authorization by MA plans.[21-23] The OIG also found that 75 percent of audited rehab hospital stays were not overturned on appeal.[21] In addition to the lack of medical necessity, the 39% FFS rehabilitation hospital marginal profit may be related to the use of prior authorization of these services.[21,23]

Gaining greater transparency into how MA plans use prior authorization is essential for better understanding how lack of payment reform in FFS impacts MA. Authorizing a unified PAC PPS could result in an equilibrium that reduces the use of prior authorization by MA plans.

Recommendations

In conclusion, I strongly recommend that this Committee move ahead with legislation that gives CMS the authority to implement a unified PAC PPS.

Thank you for the opportunity to share my perspective with the subcommittee. I look forward to continuing to work with you on these important issues.

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