House Committee on Energy & Commerce – Subcommittee on Health
"Medicare Post Acute Care Delivery and Options to Improve It"
Thursday, April 16, 2015 – 2322 Rayburn House Office Building

Testimony of Dr. Steven Landers, MD, MPH
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Good Morning Chairman Pitts, Ranking Member Green and Distinguished Members of the House Subcommittee of Health. My name is Dr. Steven Landers, and I serve as the President and CEO of the Visiting Nurse Association (VNA) Health Group. I am grateful for this opportunity to be with you today to discuss the current state of – and possible reforms to – Medicare post acute care.

By way of brief background, I am a family doctor and geriatrician, with a particular focus on the delivery of general primary care and palliative care to the elderly in their homes. Following my educational training at Case Western Reserve University School of Medicine and Johns Hopkins University School of Hygiene and Public Health, I served as Director of the Center for Home Care and Community Rehabilitation and Director of Post-Acute Operations for the Cleveland Clinic. I am board certified in Family Medicine with additional certificates in geriatric medicine and hospice and palliative medicine.

In 2012, I joined the outstanding team at VNA Health Group, the largest not-for-profit home health care provider in New Jersey and the second largest in the nation. For more than 100 years, our organization has served the most vulnerable amongst us — welcoming fragile new babies home, assisting disabled children and their parents, serving traumatically injured adults, delivering complex, specialized nursing services to seniors in the homes, and extending comfort to the terminally ill.

Today, VNAHG serves more than 100,000 individuals annually throughout New Jersey, a privilege we approach in a manner consistent with our tradition of collaboration and connectedness. Since our founding in 1912, our focus has been to serve those who are most vulnerable, through illness or social circumstance, in order that they may have a healthier, more hopeful, and dignified life.

I also serve on the Board of the Partnership for Quality Home Healthcare, which I am proud to represent here today. The Partnership is a coalition of leading home healthcare providers dedicated to advancing solutions that improve outcomes for all home health patients as well as greater efficiency and stronger program integrity requirements for the Medicare program on which they depend.

Finally, I serve as Chairman of the Alliance for Home Health Quality and Innovation and serve on the Boards of Directors of the Community Health Accreditation Partner, the American Academy of Home Care Medicine, the Greater Newark Health Coalition, the New Jersey Hospital Association Health Research and Education Trust, and the Partnership for Quality Home Healthcare. I am proud to have also recently been elected to join the Board of Directors of the Visiting Nurse Associations of America.

Today's hearing is timely as every day, Medicare beneficiaries are being discharged from hospitals and are entering the post acute care (or "PAC") system. Each of us – policymaker and provider alike – share the hope that their journey will be a positive one and that these seniors will …

- receive the care they need;
- understand – to the greatest extent possible – the path before them;
- be served in the most clinically appropriate and cost effective settings; and
- have their health and independence restored as quickly as is possible.

Unfortunately, the reality differs significantly from this vision. Too often, beneficiaries discharged hospitals experience uncoordinated and costly PAC care services. Instead of teamwork and clear care paths, there is often fragmentation and confusion. This lack of coordination can be dangerous for patients because important things about their care can be lost in their transition between care settings, and the stress and frustration can also take its toll on family caregivers who are often struggling to help their loved one while maintaining their own health. As a result, instead of efficiency, we see excessive costs being borne – by patients and the Medicare program.

I see this everyday. Like home health providers across the US, VNA Health Group serves many of the oldest and frailest beneficiaries in the Medicare program. According to an Avalere Health analysis of the Medicare Current Beneficiary Survey Access to Care File, home health patients are older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined:

Avalere Health – Home Health Beneficiary Study: Key Findings[1]	**Medicare Home Health Beneficiaries**	All Other Medicare Beneficiaries
Women	**60.07%**	53.9%
Beneficiaries aged 85+	**24.4%**	12.1%
Beneficiaries with 4+ chronic conditions	**74.7%**	48.5%
Beneficiaries needing assistance with 2+ Activities of Daily Living (ADLs)	**23.5%**	7.6%
Beneficiaries at or below 200% of Federal Poverty Level (FPL)	**66.2%**	47.9%
Beneficiaries from ethnic or racial minority population	**19.3%**	14.9%
Dual-eligible Medicare-Medicaid beneficiaries	**26.7%**	17.7%

As a result, we have seen firsthand how bewildering and burdensome the current "system" can be for Medicare beneficiaries and their families. Consider, for example, the story of a very typical beneficiary: Mrs. Smith is an 82-year-old woman with arthritis, congestive heart failure, and limited vision. She has

[1] http://homehealth4america.org/media-center/attach/207-1.pdf

just been discharged from the hospital where she had surgery to repair her broken hip. Mrs. Smith broke her hip when she tripped and fell in her home.

As Mrs. Smith nears the end of her stay in the hospital, she and her family aren't totally sure of what to do. She has a list of PAC providers in her area and has received some basic information, but everything is moving fast and she's still in pain from the surgery and sleepy from the pain medications. Her daughter, who is her main caregiver, isn't sure who is in charge of her care after she leaves the hospital. They're also not sure who to go to with questions.

In short, Mrs. Smith has several significant needs:

- She needs a holistic and comprehensive assessment of her post-hospital care needs that accounts for her medical, functional, and social/family circumstances. This assessment must lead to a patient-centered care plan that continues once she leaves the hospital, a plan that is well managed across the different post-acute providers and settings she may need.
- She needs help accessing that care in the best setting for her, as well as help to ensure her transition to that post acute care is as seamless as possible.
- She will need a range of support from registered nurses, physical and occupational therapists, social workers and physician care, ideally without the disruption and cost of ambulance transportation. She may also benefit from further evaluation of her low-vision, podiatry, and pharmaceutical needs.
- Finally, Mrs. Smith will need short-term assistance with such Activities of Daily Living as bathing and dressing while she recuperates and she may need help with nutrition (which is particularly important to seniors living alone). Depending on how well she recovers, Mrs. Smith and her family may need advice and referrals regarding long term care options.

Mrs. Smith's story isn't an atypical example. People like her are discharged from hundreds of hospitals across the country every day. They are our parents, our grandparents, our aunts and uncles and, soon, they may very well be us.

If Mrs. Smith and others like her receive the care they need, they will recuperate more quickly, at lower cost, and with a much lower risk of rehospitalization. But – too often today – they simply aren't receiving that well-coordinated care.

The reason is simple: today, too many Medicare beneficiaries like Mrs. Smith don't have the key ingredient: patient-centered care coordination.

The unfortunate reality is that, today, it's really no one's job to deliver patient-centered care coordination. No one is being paid to help Mrs. Smith with her transition from the hospital or to ensure she is able to get the right care at the right setting for her needs. Today, incentives are not aligned to get all people moving in the same direction and, as a result, patients are not being empowered or assisted, and care is not being coordinated.

If such care coordination were being consistently delivered, Medicare beneficiaries and their families would be far more likely to have what they need: a partner that's truly invested in helping them get better soon, a physician and nursing team to answer questions and monitor care, an integrated electronic health record that will help their providers have all the patient's medical information, and more.

We believe patient-centered care coordination can be achieved via PAC bundling that provides consistent support and navigation assistance to discharged Medicare beneficiaries. It's for this reason that the Partnership is pleased to add its support to the Bundling and Coordinating Post Acute Care (or "BACPAC") Act.

Under BACPAC, care coordination would begin on the day of a patient's discharge from the hospital and would continue as an episode of care for up to 90 days (unless the patient is admitted to the hospital for an unrelated condition). The BACPAC model would empower Coordinators to manage each episode. Coordinators would play an important role: they would establish provider networks consisting of licensed and accredited post-acute providers, coordinate patient care, reimburse providers within the bundle at amounts that cannot be less than those under current law, and manage the cost of the episode (either directly or via contract with third-party benefits managers or insurers). Just to become a coordinating entity, the potential candidate organizations will need to demonstrate a history of clinical and service excellence as well as competencies and capabilities, including in such critical arenas as care coordination, rehabilitation, and geriatric care.

In addition, BACPAC builds on the successful payment model for hospitals – the Diagnosis Related Group (or, "DRG") model, which has been used in hospitals for more than 30 years. Under BACPAC, Condition Related Groups (or, "CRGs") would work similarly to the way Medicare Severity DRGs do. Like DRGs, each CRG would serve as a "mini-bundle" that would account for substantially all of the care for each beneficiary. If treatment costs exceed a CRG's value or if the patient is rehospitalized for care related to their CRG condition, the Coordinator assumes full responsibility. By contrast, if costs are lower than the CRG's value, the Coordinator shares 100 percent of the savings with the discharging hospital, the

treating physician and the PAC providers who served the patient. In this way, CRGs would align incentives for improved outcomes and reduced cost.

Through its system of site-neutral CRG bundled payments and the responsibility that would be borne by Coordinators and their networks of providers and medical professionals, BACPAC would replace the artificial barriers that today impede collaboration. As MedPAC has noted, "Bundled payments … encourage providers to coordinate care to focus on managing patient outcomes and controlling costs."[2]

Just as important, this reform measure ensures patient choice and network adequacy. Under BACPAC, patients and their families are able to choose their Coordinator as well as the providers within the Coordinator's network by whom they prefer to be treated. We anticipate that patients and their families will consult with their physician and make their choices based on the quality of the care that a Coordinator's affiliated network provides, the convenience of their locations, the technologies they deploy, the strength of their nursing corps, their partnerships with key community resources like YMCA and social services, and other key factors. All of this keeps patients at the center of their care and, unlike other concepts, ensures that patients are not limited to one set of providers based on their site of hospitalization or other factors.

Importantly, the Coordinator model may also do more than any other single reform to protect the integrity of the Medicare program because it is inconceivable that any Coordinator will select a bad actor for inclusion in its network. In order to be successful, Coordinators must contract with the highest quality and most efficient PAC providers. Furthermore, Coordinators must ensure that beneficiaries have

[2] http://www.medpac.gov/documents/20130614_WandM_Testimony_PAC.pdf, p 8.
[3] "Why Health Care Is Going Home" by Steven J. Landers, MD, MPH. *New England Journal of Medicine*. October 21, 2010.

access to the same comprehensive benefits and that post-acute providers are reimbursed in the same fashion as under current law. BACPAC is about adding care coordination and oversight with the goal of optimizing care – not taking away the rights or stature of patients or community providers. Providers who cannot deliver according to those standards – including those who engage in fraudulent or abusive behavior – will find they are completely locked out of Medicare's post acute care continuum.

Significantly, BACPAC would also foster greater use of clinical and technological innovations. Today, we are seeing a renaissance in the development of innovations that can improve patient care, outcomes, efficiency, and safety. As I wrote in the *New England Journal Medicine*, for example, physicians can now carry "a new version of the black bag that includes a mobile x-ray machine and a device that can perform more than 20 laboratory tests at the point of care."[3] And yet, antiquated Medicare regulations and payment rules compromise the ability of providers to utilize technologies. BACPAC would rectify this problem by enabling funds to be used for innovations that can improve outcomes and reduce cost.

Finally, BACPAC harnesses the efficiency it will achieve in the form of savings that will help sustain the Medicare program. Specifically, BACPAC is designed to reduce overall PAC spending by 4 percent over the next 10 years, which I understand has the potential to reduce Medicare costs by tens of billions of dollars. I should note, too, that none of these savings will come from Medicare beneficiaries, since BACPAC doesn't increase the burden of out-of-pocket costs, nor would they come from cutting provider reimbursement, because BACPAC protects providers' rates and payment structure at their current levels. Instead, savings are achieved through increased coordination and efficiency, thereby ensuring that patients get the care they need in the most appropriate and cost-effective settings while preventing unplanned, high-cost interventions such as ER visits and hospitalizations.

In short, BACPAC would build on the successful DRG precedent by creating a system of condition-specific CRGs that would strengthen care coordination, improve patient outcomes, ensure patient choice, and achieve significant savings. In contrast to the challenges which compromise post-acute care today, the BACPAC model would:

- Break down the barriers that today impair quality and produce inefficiency;
- Foster care coordination across today's siloes and among multiple providers;
- Enable care to be delivered in clinically appropriate and cost-effective settings;
- Permit investment in technologies and innovations that will lead to truly connected care;
- Align with Congress' passage of the IMPACT Act which created a unified PAC data tool; and,
- Achieve significant savings while rewarding physicians and providers for delivering quality care.

In closing, I would like to thank you again for convening this hearing and the privilege of participating in it. I also wish to express our appreciation and respect to the Committee and to Representatives David McKinley, Jerry McNerney, Tom Price and Anna Eshoo and their talented staff for their extraordinary work on and support for this complex but vitally-needed step forward. America's seniors deserve a Medicare program that provides high-quality preventive, therapeutic, rehabilitative and palliative care, and they want Medicare to be a program that will not burden their children and grandchildren with unsustainable costs.

We recognize that there are many complex issues that need to be worked through as you contemplate post acute care reform. My one request as you do so is to keep Mrs. Smith and seniors like her in mind. Their needs are real, and the current PAC system is not properly structured to meet them. As a result, the opportunity before you is not only to achieve real efficiency and improvement in Medicare post

acute care policy – it's to help ensure that Medicare post acute care policy works for the most vulnerable among us.

I know I speak for all my colleagues throughout the post acute care continuum when I express our gratitude for your dedication and service and extend an offer to assist you in any way we can.

Thank you.

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Summary of Dr. Steven Landers Testimony

- Today's hearing is timely and needed. Seniors discharged from hospitals are finding themselves in a poorly-coordinated and costly post-acute care continuum. Instead of order, there is disarray. Instead of teamwork and clear paths, there is fragmentation and confusion. And instead of efficiency, excessive costs are being borne by patients and taxpayers alike.

- VNA Health Group serves some of the oldest and frailest beneficiaries in the Medicare program. As a result, we have seen firsthand how bewildering and burdensome the current "system" is for ailing seniors and their families.

- Consider the example of Mrs. Smith:
  - Mrs. Smith is an 82-year-old woman with arthritis, congestive heart failure, and limited vision.
  - She is being discharged from the hospital where she was treated for a broken hip caused by a fall.
  - She has received some information but is still in pain and sleepy – she and her family aren't sure of what to do.
  - Her daughter, who is her main caregiver, isn't sure who is in charge post-discharge or who to go to with questions.

- Mrs. Smith has a number of basic – but important – needs, including:
  - a comprehensive and holistic assessment of her post-hospital needs and circumstances;
  - help accessing the care she needs in the setting that's right for her condition;
  - support from registered nurses, licensed therapists, social workers, and physicians; and,
  - short-term assistance with Activities of Daily Living and nutrition while she recuperates.

- Mrs. Smith's story isn't an atypical example. Patients like her are discharged from hundreds of hospitals every day. They are our parents, our grandparents, our aunts and uncles and, soon, they may be us.

- If Mrs. Smith and seniors like her receive the coordinated care they need, they will recuperate more quickly, at lower cost, and with a much lower risk of rehospitalization. But – too often today – they simply aren't receiving such care.

- Seniors like Mrs. Smith don't have what they need most: <u>patient-centered care coordination</u>.
  - Patient-centered care coordination means a partner that's truly invested in helping discharged patients get better soon, a physician and nursing team by their side every step of the way, an integrated electronic health record to avoid adverse events, and more.

- We believe patient-centered care coordination can be achieved via PAC bundling that adapts the successful DRG model and provides consistent coordination and navigation support to discharged beneficiaries and their families. It's for this reason that the Partnership is proud to add its support to the BACPAC Act.

- The BACPAC model incorporates elements that we feel are critical to patient-centered care coordination:
  - It is modeled on Diagnosis Related Groups (or "DRGs") which have been in use for over 30 years.
  - It creates DRG-like Condition Related Groups (or "CRG") to align interests and improve outcomes.
  - It ensures patient choice, network adequacy, and use of clinical and technological innovations.
  - It uses powerful risk and savings incentives to prioritize high-quality, consistently coordinated care.
  - It strengthens program integrity since no Coordinator will select a bad actor to be in its network.
  - It aligns with Congress' passage of the IMPACT Act, which created a unified PAC assessment tool.
  - And it achieves significant savings without cutting any provider or increasing costs for any senior.

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