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TESTIMONY TO THE HOUSE COMMITTEE ON WAYS & MEANS FOR A *HEARING ON MEDPAC'S JUNE REPORT TO CONGRESS* ON JUNE 18, 2014

The American Health Care Association (AHCA) respectfully submits the following testimony to the Members of the House Committee on Ways & Means in regard to the *Hearing on MedPAC's June Report to Congress* on June 18, 2014. With more than 12,000 skilled nursing center members, AHCA is committed to improving lives by delivering solutions for quality care.

To that end, the Association stands ready to work with the Congress on strategies to improve post-acute care (PAC) payment systems which will improve the quality of care for people, produce Medicare programmatic efficiencies, and support a dynamic and innovative PAC sector. The latter is particularly important as the Centers for Medicare and Medicaid Services (CMS) and states experiment with alternative payment methods (APM) and delivery systems both for Medicare-only beneficiaries and persons who are eligible for Medicare and Medicaid (e.g., duals).[1] All of these efforts are aimed at improving beneficiary outcomes and addressing Medicare spending, which will significantly grow as the baby boom generation reaches retirement age.[2]

Already, AHCA worked with the Congress on the Skilled Nursing Facility Hospital Readmission Reduction Program contained in the *Protecting Access to Medicare Act of 2014* (P.L. 113–93). The Association has had a hospital readmission goal as part of its Quality Initiative for over three years. Now, the most recent data shows that skilled nursing centers are reducing rehospitalization rates. Furthermore, the recently enacted law establishes specific targets to further encourage nursing facilities to better coordinate care with hospitals, physicians, and other post-acute care providers, as well as save the Medicare system $2 billion in the next 10 years.

To further enhance Medicare beneficiary care and shore up the Medicare program, the Association supports the development of site neutral system and believes that MedPAC's efforts lay a strong foundation for moving forward expeditiously. We propose that the Congress:

1. Adopt MedPAC's recommendation and pass legislation to implement a site-neutral payment system for select orthopedic conditions treated in both inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs);
2. Hold on the implementation of waivers. There are waivers that we believe should be granted for SNFs, such as the 3-day inpatient hospital requirement, but final

[1] These include accountable care organizations (ACO), bundling, and CMS' Financial Alignment Demonstration. Medicare Advantage is not new to Medicare but it's rapid expansion and plan control over site of care also must be considered.
[2] Congressional Budgeting Office. The Budget and Economic Outlook: 2014 to 2014. February 2014.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

judgment on waivers cannot be made until the fundamental analyses that need to be done are completed. Similarly, we believe that research is needed on IRF waivers before they are granted.

3. Swiftly pass the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

Site Neutral – An Opportunity for Exploration

Currently, the Medicare system reimburses each type of PAC provider according to different payment methodologies. Existing payment policies focus on phases of a patient's illness defined by a specific service site, rather than on the characteristics or care needs of the Medicare beneficiary. As a result, patients with similar clinical profiles may be treated in different settings at different costs to Medicare. This payment system fails to encourage collaboration and coordination across multiple sites of care and provides few incentives that reward efficient care delivery. Such misalignment long has been understood and acknowledged.

Years ago, key policy thinkers, institutes and government agencies started to address the failures and to develop concepts that in effect were "site-neutral." Site neutral means that care should be patient-centered organized around the individual's needs, rather than around the settings where care is delivered.

In recent years, a number of efforts have laid the foundation for a site neutral system. Most recently, MedPAC unveiled its case for site-neutural payments for several conditions that are treated in both SNFs and IRFs. Its data and analyses are compelling and groundbreaking. The Commission's work is the culmination of two years of site neutral policy analysis and builds upon a strong movement toward the need for a site neutral policy that began in 2005. A few of the key milestones include the following:

- In May of 2005, the CMS Administrator created a Policy Council to improve our nation's health care system. One of the Council's first priorities was to develop a plan for PAC reform. The Council developed a set of PAC reform principles to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.

- The Deficit Reduction Act (DRA) of 2005 mandated a demonstration that also supports site neutral. The DRA effort resulted in the development of a common assessment tool which could facilitate significant movement toward the ability to compare patients across settings as well as reshape current PAC payment systems to pay for similar services to similar patients despite the settings.

- Released in 2011, the "President's Plan For Economic Growth And Deficit Reduction, Legislative Language and Analysis," the Budget proposed to restructure PAC payments. The legislative language adjusted Medicare payments

for three conditions involving hip and knee replacements and hip fracture as well as other conditions selected by the Secretary at her discretion. The Budget document indicated that these conditions are commonly treated at both IRFs and SNFs, but Medicare pays significantly more when treated in IRFs. The Budget document clearly articulated that IRFs provide intensive inpatient rehabilitation care that may not be needed for patients with certain conditions and whose care needs could reasonably be expected to be met in a SNF.

- In the April 2013 Moment of Truth Project report, "A Bipartisan Path Forward to Securing America's Future," the Co-Chairs, Erskine Bowles and Senator Alan Simpson, proffered a plan to put America's fiscal house in order. As part of the plan, they proposed reforming PAC payments and included a proposal to equalize payments between across PAC settings.

- President Obama's fiscal year 2014 budget also proposed a restructure of PAC payments for three conditions, involving hip and knee replacements and hip fractures as well as other conditions to be selected by the Secretary of Health and Human Services.

- In March 2014, MedPAC unveiled its work on site-neutral PAC. The Commission examined three specific conditions (stroke, major joint replacement, and hip fractures) and concluded the following:

  - For select conditions, characteristics of beneficiaries admitted to IRFs and SNFs in the same market were similar;
  - In addition, the prevalence of comorbidities of beneficiaries were similar but patients treated in SNFs were more likely to have several of the comorbidities; and
  - Where available, risk adjusted measures indicated few differences between IRFs and SNFs for identified conditions. Specifically, the research showed no significant differences in risk-adjusted readmission rates between IRFs and SNFs, no significant differences in mobility, and, with respect to self-care, there were no significant differences for orthopedic conditions but some higher rates of improvement for IRF patients.

Most recently, in its June 2014 Report to Congress, MedPAC elaborates upon its March 2014 statements. Specifically, in the June 2014 report, the Commission examined three conditions – stroke rehabilitation, major joint replacement, and other hip and femur procedures – and found that patients and outcomes for orthopedic conditions were similar and such cases represent a strong starting point for a site neutral policy when using risk adjusted measures.

However, the efforts listed above as well as MedPAC research all are limited by data. Additional resources and study are needed to ensure a viable patient-centered system based upon a site neutral payment system will be successful and produce the desired

outcomes for people as well as the Medicare program and support a dynamic and innovative PAC sector.

AHCA recommends that the Congress adopt MedPAC's recommendation and pass legislation to implement a site-neutral payment system for select orthopedic conditions treated in both IRFs and SNFs.

The U.S. Department of Health and Human Services, recent Congressional legislation (e.g., the Deficit Reduction Act, the IMPACT Act of 2014), the Administration, and MedPAC all have examined approaches to rationalizing payments across different provider types and settings. Last year MedPAC began an examination of how Medicare could equalize payments for similar patients treated in long-term care hospitals (LTCHs) and acute care hospitals. In his remarks to Congress in 2013, the MedPAC executive director indicated that equal payments for similar PAC services would build on the Commission's work examining Medicare's payments for select ambulatory services.

In its most recent *Report to the Congress,* MedPAC states the following:

> "Site-neutral payments stem from the Commission's position that the program should not pay more for care in one setting than in another if the care can be safely and efficiently (that is, at low cost and with high quality) provided in a lower cost setting. As a prudent purchaser protecting the taxpayers' and beneficiaries' interests, Medicare should base its payments on the resources needed to treat patients in the most efficient setting, adjusting for patient severity differences that could affect providers' costs."[3]

In their analysis MedPAC selected three conditions to study, allowing them to explore a "proof of concept" of site-neutral payments between IRFs and SNFs. Those conditions included patients receiving rehabilitative care following a stroke, major joint replacement, and other hip and femur procedures (e.g., hip fracture). They found that patients and outcomes for stroke rehabilitation were more variable and concluded that additional work needs to be done to more narrowly define those cases that could be subject to a site-neutral payment policy and those that could be excluded from it. However, they found that the patients and outcomes for the orthopedic conditions were similar and could be a strong starting point for implementation of a site-neutral payment policy.

The Commission explains that site-neutral payments for orthopedic conditions could be implemented in the near-term and would serve as building blocks for broader payment reforms such as bundled payments and Accountable Care Organizations (ACOs). AHCA supports MedPAC's position on site-neutral payments and recommends that the Congress swiftly pass legislation to implement site-neutral payments for select conditions treated in both IRFs and SNFs.

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[3] *Report to the Congress: Medicare and the Health Care Delivery System*, June 2014, page 97.

Immediate movement on MedPAC's suggested site neutral approach is needed (e.g., testing for specific conditions). Efforts to maximize the potential of ACOs, bundling, and other potential care/payment reforms depend upon the alignment of care across the acute and post-acute spectrum. If such efforts are not undertaken, inappropriate cost data, inappropriate Medicare payment, and clinically inappropriate sites of care will be drawn into the fabric of the new systems and contribute to their failure.

AHCA recommends that the Congress swiftly pass the IMPACT Act of 2014.

There is currently no way for policymakers and health care analysts to compare patient outcomes and functional status across care settings because there is no unified assessment tool for providers to use to capture this information. Absent this data, it is difficult to move forward with meaningful reforms that would rationalize payment systems across PAC providers. Standardized post-acute assessment data are the necessary building blocks for any meaningful payment reform that would rationalize payments across PAC settings.

MedPAC first raised the need for a common PAC assessment tool in 2005[4]. In the Deficit Reduction Act of 2008, the Centers for Medicare and Medicaid Services was first directed to test the concept of a common standardized assessment tool in the form of the post- acute care reform demonstration. In their March 2014 *Report to the Congress,* MedPAC recommended that Congress enact legislation that would implement a common assessment tool across PAC providers. AHCA supports that recommendation.

Last year the Chairmen and Ranking Members from both the Senate Finance Committee and the House Ways and Means Committee invited Medicare PAC stakeholders to provide their ideas and solutions for PAC reform. The Committees received more than 70 letters from stakeholders (including AHCA) echoing the need for standardized post-acute assessment data across Medicare PAC provider settings. In March of this year, in response to overwhelming support for such a policy, staff of the House Ways and Means and Senate Finance Committees released a discussion draft of a legislative proposal outlining a policy that would begin the implementation of a common assessment instrument across PAC settings.

That proposal, titled the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014,* would require PAC providers to begin reporting standardized patient assessment data by October 1, 2018, (and January 1, 2019, for home health agencies [HHAs]) by integrating common questions into individual provider sectors' existing patient assessment instruments. AHCA supports this proposal and recommends that the Congress waste no more time in enacting the legislation.

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[4] *Report to the Congress: Medicare and the Health Care Delivery System*, June 2005, page 119.

AHCA Site Neutral Concept

We strongly support a PAC site-neutral payment system which would restructure Medicare to revolve around the beneficiaries' needs rather than around the settings where care is delivered. The Association is examining a site-neutral solution to improve and stabilize the Medicare program.

Under AHCA's solution, patients would be grouped by their clinical condition and severity of illness. Each group would have a set Medicare payment that would cover the expected costs of providing the appropriate type, duration and mix of services. Medicare payments would be the same for each PAC provider regardless of where the patient is being treated.

We would achieve such programmatic changes by:

1. Moving forward with MedPAC's initial steps,
2. Studying which conditions could be added to a site neutral system; and
3. Gathering data that would allow for additional comparative analysis of SNF and IRF settings under the auspices of the IMPACT Act.

This person-centered PAC approach would level the "paying" field to motivate providers to offer the highest quality option in order to continue receiving patients. Additionally, a site-neutral payment system would further care coordination and collaboration between providers. Such incentives are beneficial for seniors, who would receive better care, as well as taxpayers, who would enjoy a more cost-effective Medicare system.

Conclusion

As noted above, we are not alone in our support of a site neutral arrangement. Acknowledgements by the Administration and non-partisan groups reflect growing interest in implementation of a site-neutral payment policy.

We can prevent the looming Medicare solvency crisis as 10,000 of our nation's baby boomers turn 65 with each passing day. America's skilled nursing care centers are developing solutions that will combat efficiency problems including a site-neutral payment policy for PAC providers. A site neutral payment policy solution is not only better for the government and taxpayers, it is also better for people and their families. The Association is ready to address our nation's fiscal issues with this concept and looks forward to working with Congress on site neutral payment policy and other critical health care policy solutions and issues.