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CONGRESSIONAL HEARING REPORT

DATE OF HEARING: June 16, 2005

SUBJECT: Hearing on Post-Acute Care

COMMITTEE: House Committee on Ways and Means,
Subcommittee on Health

STAFF MEMBER COVERING HEARING: Garrett H. Donovan

Members Present

Republicans: Subcommittee Chairman Johnson (CT); Representative Johnson (TX);
Representative Hayworth (AZ); Representative Hulshof (MO); and
Representative Camp (MI)

Democrats: Representative Lewis (GA); Representative Thompson (CA)

Witnesses

Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission
(MedPAC)

Majorie Kanof, M.D., Managing Director, Health, U.S. Government
Accountability Office (GAO)

Herb Kuhn, Director, Center for Medicare Management, Centers for
Medicare and Medicaid Services (CMS), U.S. Department of Health and
Human Services

Carol Raphael, President and Chief Executive Officer, Visiting Nurse
Service of New York

Mary Ousley, R.N., Executive Vice President, Sunbridge Healthcare

Gerben DeJong, Ph.D., Senior Fellow, National Rehabilitation Hospital

John Votto, D.O., President and Chief Executive Officer, Hospital of
Special Care

Pat Rice, R.N., President, Select Medical Corporation
Toby Edelman, Senior Policy Attorney, Center for Medicare Advocacy

Opening Remarks

Subcommittee Chairman Johnson opened by outlining the current state of post-acute care facilities. She stated that over time, each type of entity has evolved into a separate system. Chairman Johnson explained that the development of a common patient assessment tool for post-acute care services remains a high priority for the Committee. She further highlighted the need to create a more rational post-acute payment structure, commenting that payments should be tied to the services required by the patients, rather than the institutional setting in which patients are placed.

Rep. Lewis explained that although post-acute care is an important issue, the Committee should be focusing on oversight of the Medicare prescription drug benefit. He elaborated, stating that 90 percent of Medicare enrollees will be impacted by the new prescription drug plan and that the Committee must ensure that the necessary funding will be provided.

Testimony – First Panel

Glenn Hackbarth testified that the underlying issue regarding post-acute care is that there are no clear and comprehensive criteria for determining which post-acute setting is best for patients with particular needs. He explained that since post-acute care settings have evolved separately, they may not form an integrated whole to provide the highest possible care with the best value. He added that skilled nursing facilities (SNFs) and home health setting payments are not representative of patients' conditions. **Mr. Hackbarth outlined several MedPAC recommendations for improving the payment systems for the post-acute care sectors. They include:**

- **Reforming the prospective payment system (PPS) for SNFs because the current system does not pay accurately for all of its patients and encourages providing rehabilitation services at the expense of caring for patients who have medically complex conditions.**
- **Reexamining the home health PPS because the services now provided are different than those provided when the system was created and payments may not be accurate.**
- **Creating facility level criteria to better define long-term care hospitals (LTCHs), and patient level criteria to better define who should go to those facilities.**
- **Instituting a pay for quality performance program for home health, and creating quality measures for SNFs.**

Mr. Hackbarth also explained that aside from an overhaul of the payment systems, there is a need to evaluate outcomes and the quality of care and to ensure that beneficiaries are sent to the most clinically appropriate and cost-effective setting. These changes, Mr. Hackbarth emphasized, could provide better care for beneficiaries and better value for the Medicare program.

Marjorie Kanof discussed the report released by the GAO entitled *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities*, which was released in April. She explained that since patients treated at inpatient rehabilitation facilities (IRFs) require more intensive rehabilitation than those at other facilities, Medicare pays for treatment at a higher rate. She stated that in order to differentiate IRFs from less intensive settings, CMS utilizes the 75 percent rule, which requires a facility to show that during a 12-month period, at least 75 percent of patients required intensive treatment of at least 1 of 13 listed conditions. She maintained that IRF compliance with the 75 percent rule has been problematic, with some IRFs questioning the requirements and arguing that the list should be updated. She provided details of the April report, explaining that fewer than half of all IRF Medicare patients were admitted for having a condition on the 75-percent list. Dr. Kanof cited an example, commenting that almost half of all patients with conditions not on the list were admitted for orthopedic conditions, with most involving joint replacements. **She reported that the GAO analysis concluded that condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, that more conditions should not be added to the list, and that the rule should be refined to clarify where patients should be referred.**

Herb Kuhn commented that CMS has undertaken a variety of activities to develop more consistent payment and assessment systems. **He stressed the importance of having a more comprehensive system where the incentives are to place the patient in the most appropriate post-acute care setting rather than the setting where the payment is advantageous to the provider. Mr. Kuhn advocated a system where standardized payment and patient assessment data elements would make it possible to evaluate health and functional status across the settings, with uniform payments for clinically similar admissions and a consistent set of incentives.** He further explained that greater integration and coordination in Medicare's post-acute care payment system could enhance the focus on patient need while at the same time reducing unnecessary transfers between settings.

Q & A

Subcommittee Chairman Nancy Johnson stated that she believed that a single assessment tool is necessary, although she acknowledged it may not be easy to implement. She commented that episode payments may incentivize nursing homes, leading to a shift from home health. **She stressed that the system should be patient-centered, rather than facility-centered.** **Mr. Hackbarth** responded that the decline in home health care would be more dramatic among lower level users, but he believed that a state-level relationship did not necessary exist. He added that some statutory changes could be made to impact qualification. **Subcommittee Chairman Johnson** spoke about discharge planning, asking witnesses how much of the problem is medically driven. **Mr. Hackbarth** replied that there is not a clear criteria regarding patient assignments and that the incentives are not right for hospital discharge plans.

Rep. John Lewis asked the panel to comment on the MedPAC recommendations. **Mr. Kuhn** agreed that a common assessment tool is necessary to impact change. **He further noted that minimum data sets are necessary to identify the highest points of function at all**

levels. **Rep. Lewis** asked what lessons have been learned over the past 15 years. **Mr. Kuhn** responded that the 1990's marked a period of rapid growth and in 1997 rapid payment systems were identified. He commented that an assessment of post-acute care should be the next order of business. **Rep. Lewis** asked whether the CMS 3-year transition period is properly justified. **Dr. Kanof** responded that there is value in the 3-year transition period, but that CMS must work to clarify the subgroups.

Rep. Sam Johnson asserted that there have been some complaints about the GAO report, explaining that he believed that researchers only spent one day at the Institute of Medicine (IOM) and did not interview more than a dozen people. **Dr. Kanof** defended the methodology that the GAO used to prepare the report, adding that interviewers met with about 107 people. **Rep. Johnson** asked whether the 3-year transition period should be examined or possibly extended. **Dr. Kanof** replied that it should partly depend on the amount of money being spent, noting that joint replacement recovery would not warrant the degree of care that it has been receiving. **Mr. Kuhn** responded that he believed that it was too early to evaluate the transition period and that more data would be needed to ensure that overpayments are not made.

Rep. Mike Thompson asked what was learned from the MedPAC report. **Mr. Kuhn** replied that prospective payment systems have been completed, but now must be implemented. He also stated that more research would be necessary in the future. **Rep. Thompson** asked how much of the siting argument was based in state law. **Mr. Hackbarth** responded that state law does have an impact on siting. He further commented that a common diagnosis alone would not be sufficient to determine the necessary degree of care.

Rep. Kenny Hulshof remarked that current incentives are skewed. He stressed that the system should focus on patient-centered care and those with functional disabilities. He asked how CMS is going to incorporate functional measures. **Mr. Kuhn** responded that the 75-percent rule was suspended in 2002, which was followed by a spike in utilizations. He further maintained that more research would be necessary.

Subcommittee Chairman Johnson acknowledged that there are serious problems with the current system. She stated that a report was requested 5 years ago, which CMS was supposed to have prepared by this past January. **Mr. Kuhn** replied that progress is being made, but not at the pace expected. He commented that he was not able to give a delivery date for the report, but agreed to provide Committee staff with periodic updates. **Subcommittee Chairman Johnson** asked how the witnesses view the 25-percent rule for LTCHs. **Mr. Kuhn** responded that CMS is currently moving aggressively with its research. **Subcommittee Chairman Johnson** explained that she hoped to eliminate the 25-percent rule because she believed that it is totally arbitrary and not patient-centered.

Second Panel - - Testimony

Mary Ousley testified that the fragmented structure of post-acute care settings has become problematic. She commented that the degree of care should be determined by required services, rather than where the patient is located. **She stated that it was essential for CMS to**

develop a patient-centered core uniform screening and assessment tool for post-acute care, and a uniform integrated payment system based on the comprehensive assessment tool. She explained that CMS can do a better job of placing post-acute patients in the most appropriate care setting through the use hospital discharge planning programs.

Carol Raphael asserted that post-acute care decisions should be determined by patient characteristics and needs. She recommended that a mechanism be developed that compares patient characteristics, patient outcomes, and costs across settings. She further requested that a uniform assessment process be developed to assess patients at the same points in time, such as every 60 days. Mrs. Raphael commented that an assessment process should not replace the outcome assessment information set (OASIS) or any other existing tool, but should have the specific purpose of identifying upfront which type of post-acute care would produce the best outcome for the least amount of money based on the standard criteria and patient choice.

Gerben DeJong testified that although similar patients are seen in different post-acute venues, that it would be difficult to find or create one tool that can capture the full range of patient needs across all settings. He argued that by trying to create an all-inclusive instrument, there is an increased risk that a system could be developed which would not apply to many patients. He explained that a common assessment tool must have a clearly defined purpose and framework. He further believed that tests must be run for relevance, clarity, validity, inter-rater reliability, internal consistency, redundancy, and respondent burden. He also suggested that developers should consider using computer-aided dynamic testing technologies that enable functional status using fewer data points.

John Votto testified about the need to create an appropriate patient assessment tool and safeguards which assure that Medicare beneficiaries receive care in the most appropriate, cost-effective, and safe setting. Mr. Votto focused his remarks on data sets which could help the Secretary of Health and Human Services in the establishment of an assessment tool. He stressed the need to collect data for wound care, cardiac, and other classes of patients admitted to long-term hospitals. Mr. Votto also recommended the construction of a post-acute database which would allow for the establishment of an assessment instrument. A valid post-acute assessment instrument, he explained, would allow for consideration of whether a uniform payment system could account for the variation in patient cost and resource use across post-acute provider types.

Pat Rice supported the development of a post-acute assessment tool, as a prerequisite to integrating care, and possibly payment, across the post-acute setting. She agreed with the premise of MedPAC's recommendation that the decision should be made based primarily on patients' clinical characteristics and needs. She stated that policy should allow for some flexibility so that clinical judgment could be exercised in the best interest of patients. **Furthermore, Mrs. Rice commented, policy should not only require that patients be placed in the appropriate setting, but that providers in the post-acute sector have the capacity to meet the needs of patients.** She asserted that decisions must be made in light of patient needs and quality of care, as measured by the providers' capacity to effectively treat patients with certain clinical conditions.

Toby Edelman stated that a key purpose of utilizing a uniform assessment instrument is to save public money. **She explained that it makes little sense to pay vastly different amounts for the same services, based solely on the setting of care. She cited examples of past cost-containment efforts, warning the Committee that there are often unintended consequences.** Mrs. Edelman commented that accurate and comprehensive assessments must be provided to ensure that Medicare beneficiaries get the care and services they need in the appropriate setting of their choice. However, she remarked, if paying the lowest rate possible is the primary public goal of uniform assessments, beneficiaries may not be served well and it may create a false sense of savings if costs are simply shifted elsewhere.

Q & A

Subcommittee Chairman Johnson commented that she believed that there was a good body of information regarding the development of a universal assessment tool, but that more studies would still need to be conducted. **Dr. DeJong** responded that it would be difficult to get a consensus on the core issues, as each sector has cultural issues which may differ from the others. **Mrs. Ousley** replied that there should be enough data to span across all elements. She emphasized that a solution must define care, link to payments, and retain outcome measures.

Rep. Lewis admitted that the subject matter was outside the scope of the hearing, but stated that he is concerned about Medicaid cuts. He asked the panel whether Medicaid cuts would have a negative impact on their respective health care sectors. He also asked witnesses to comment on their assessments of the Medicare prescription drug plan. **Mrs. Ousley** replied that Medicaid cuts may hurt skilled nursing programs and added that she was still trying to determine how to manage a prescription drug program. **Mrs. Raphael** responded that her organization manages many dual-eligible beneficiaries and that she did not know how they would be effected. **Dr. DeJong** commented that the prescription drug plan is very confusing and asserted that beneficiaries would not be able to understand. **Subcommittee Chairman Johnson** concluded by taking several minutes to argue that the prescription drug plan has been well thought out and would positively impact beneficiaries.