

# POST-ACUTE CARE

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED NINTH CONGRESS  
FIRST SESSION

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JUNE 16, 2005  
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## **POST-ACUTE CARE**

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**THURSDAY, JUNE 16, 2005**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 1:08 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.  
[The advisory announcing the hearing follows:]

# ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

## SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE  
June 09, 2005  
HL-6

CONTACT: (202) 225-1721

### **Johnson Announces Hearing on Post-Acute Care**

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on post-acute care. **The hearing will take place on Thursday, June 16, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

#### **BACKGROUND:**

Medicare currently pays for post-acute care in four separate settings: long term acute care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and in the home. Medicare is currently spending more than \$30 billion annually in these four settings, with spending in SNFs and home health making up the largest portion.

Medicare reimburses for these services in these settings according to four separate payment methodologies. In addition, each setting uses a different patient assessment instrument to evaluate the level of care a patient requires (or, in the case of LTCHs, no patient assessment tool at all). Each assessment instrument and payment system was developed separately and the payment rates and tools have evolved over time into separate silos of care. As a result of these separate systems, the current payment methods differ based on the setting in which a beneficiary receives care.

In its June 2004 report to Congress, the Medicare Payment Advisory Commission examined some of the significant payment differentials that exist across post-acute care settings for the same or similar services. For example, payments for a hip fracture patient in 2004 were \$44,633 per case in an LTCH, \$18,487 in an IRF, and \$10,618 in a SNF. Because there are no common patient assessment tools or outcomes measures across settings, it is difficult to know whether patients are being treated in the most appropriate setting and whether Medicare dollars are being allocated appropriately.

Congress sought to address this problem in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554). The BIPA required the Secretary of the U.S. Department of Health and Human Services to submit a report on the development of standard instruments for the assessment of the health and functional status of Medicare patients in certain settings. This report has not yet been received, and the hearing will examine what progress has been made in this area.

In announcing the hearing, Chairman Johnson stated, "The development of a common patient assessment tool for post-acute care services remains a high priority. In light of the rapid growth in payments in post-acute settings, the development of a common patient assessment tool and the creation of a more rational post-acute pay-

ment structure, one that is tied to the services required by the patients rather than the institutional setting in which patients are placed, should be a high priority for the Congress and the Medicare program.”

#### **FOCUS OF THE HEARING:**

The hearing will focus on current financing for post-acute care services in Medicare; the services available across the various post-acute settings; the patient assessment instruments used in each setting and the commonalities between them; and prospects and suggestions for moving ahead with a common patient assessment tool and more rational payment system based on beneficiary need rather than institutional setting.

#### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please Note:** Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “109th Congress” from the menu entitled, “Hearing Archives” (<http://waysandmeans.house.gov/Hearings.asp?congress=17>). Select the hearing for which you would like to submit, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, completing all informational forms and clicking “submit” on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, June 30, 2005. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

#### **FORMATTING REQUIREMENTS:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and **MUST NOT** exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good afternoon, everyone. My apologies for starting a little bit behind schedule. I am very pleased to be chairing this hearing on post-acute care in the Medicare program. Medicare currently pays post-acute care in four separate settings: Long-Term Care Hospitals (LTCH); Inpatient Rehab Facilities (IRF); Skilled Nursing Facilities (SNF); and in the home through the home health benefit. Medicare is currently spending more than \$30 billion annually in these four settings, with spending on SNFs and home health making up the largest portion. Medicare reimburses for these services, in these settings, according to four separate payment methodologies. In addition, each setting uses a different patient assessment instrument to evaluate the level of care a patient requires, or, in the case of LTCHs, no patient assessment tool at all. Each assessment instrument and payment system was developed separately, and the payment rates and tools have evolved over time into separate silos of care. As a result of these separate systems, the current payment methods differ based on the setting in which a beneficiary receives care. In its June 2004 report to Congress, the Medicare Payment Advisory Commission (MedPAC) examines some of the significant payment differentials that exist across post-acute care settings for the same or similar services. For example, payments for a hip fracture patient in 2004 were 44,633 per cases in an LTCH, 18,487 in an IRF, and 10,618 in an SNF. Because there is no common patient assessment tool or standardized outcome measurements across settings, it is difficult to know whether patients are being treated in the most appropriate setting and whether Medicare dollars are being allocated appropriately or efficiently.

We in Congress ought to address the problem. The Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act, BIPA, of 2000, (P.L. 106-554) required the Secretary of Health and Human Services (HHS) to submit a report on the development of standard instruments for the assessment of the health and functional status of Medicare patients in certain settings. The report on this instrument was due on January 1 of this year and has not yet been received. Today, I strongly hope that we will learn from the Administration what progress has been made in this area. I am pleased to have with us today two distinguished panels of witnesses to help us explore the issues facing the post-acute care system. On our first panel we welcome back Glenn Hackbarth, Chairman of MedPAC. Mr. Hackbarth will discuss the work that MedPAC has done recently in evaluating patient assessment tools used in different post acute settings, as well as recommended payment adjustments to post-acute care providers. Then we will hear from Marjorie Kanof, a managing director for health at the U.S. government Accountability Office (GAO). She will discuss GAO's recent report on patient criteria for IRFs. Finally on our panel we will hear from Herb Kuhn, director of the Centers for Medicare and Medicaid Services (CMS). The CMS has done some work, to this point, to develop a common patient assessment tool, and Mr. Kuhn will report on those efforts by the agency.

Our second panel is comprised of people working in post-acute care industries along with a beneficiary representative. Through this testimony we will begin to understand the range and diversity

of services offered in the post-acute care area. It is my hope that the witnesses will provide us with greater understanding of what different settings have in common along with those services that make each setting unique. I am also hoping that they will provide us with their ideas as to how we can move toward a common patient assessment system and more rational payment structure for post acute services in Medicare. On this panel we will hear from Carol Raphael, President and Chief Executive Officer (chief executive officer) of Visiting Nurse Association of New York; Mary Ousley, Executive Vice President of Sunbridge Healthcare in Albuquerque, New Mexico; Dr. Gerben DeJong, a senior fellow at the National Rehabilitation Hospital; Dr. John Votto, President and chief executive officer of the Hospital of Special Care in my hometown of New Britain; Pat Rice, President and Chief Operating officer of Select Medical Corp. in Mechanicsville, Pennsylvania; and Toby Edelman, senior policy attorney at the Center for Medicare Advocacy.

In light of the rapid growth in payments in acute care settings, it is critical that we carefully examine the patient assessment tools and payment policies in each of these settings to ensure that taxpayer dollars are being spent appropriately and that beneficiaries are receiving the services they need in the setting that is right for them. The development of a common assessment tool in the creation of a more rational post-acute care payment structure, one that is tied to the services required by the patient rather than the institutional setting in which the patient finds themselves, must be a high priority for Congress and the Medicare Program. I look forward to hearing from all the witnesses on this important issue. I would now like to turn to Mr. Lewis, who will speak for Mr. Stark.

Mr. LEWIS. Thank you very much, Madam Chair. Madam Chair, I would like to thank you for having this hearing. I would like to welcome the Members of our two panels and thank them for being here today. I am pleased that we are having an oversight hearing on some of Medicare's basic obligations, because we have not done enough oversight in recent years. It is important to review what is happening with post acute services because of the amount of money being spent in this area and the number of patients affected. However, I can't help but note that there are much larger problems that we should be focusing on. Madam Chair, I hope that we would have oversight hearings on implementation of the Medicare prescription drug program. While one-third of hospitalized beneficiaries use post-acute care, 90 percent of all beneficiaries use outpatient prescription drugs. In addition, Medicare spends more than \$30 billion annually for post-acute care but is projected to spend almost double that in the first year of Part D.

Last week several troubling stories came to light. The CMS sent empty envelopes to some low-income beneficiaries. There is not enough funding to implement the new drug program. It is clear that oversight is needed. I hope that we would devote Committee time to real oversight on Medicare Part D. Although it is not the most pressing issue Medicare faces, today's topic is important; it is very important. I hope this is the first small step toward creating a more rational post acute system. I look forward to today's testi-

mony, and I thank each and every one of the panelists for being here today. Thank you, Madam Chair.

Chairman JOHNSON. Thank you very much, Mr. Lewis. Welcome to the Members of the first panel. Mr. Hackbarth will you please begin.

**STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN,  
MEDICARE PAYMENT ADVISORY COMMISSION**

Mr. HACKBARTH. Thank you, Chairman Johnson and Mr. Lewis and other Members of the Subcommittee. About one-third of Medicare beneficiaries discharged from acute hospitals receive post-acute care within 1 day of their discharge. That is, care in a SNF, home health agency, IRF, or LTCH. A little more than a third of that group go to SNFs, another third receive home health care, and a final third go to either an IRF, a LTCH, or a combination of post acute settings. Of course, other beneficiaries go to hospice to receive end-of-life care. In 2004, Medicare spent \$43 billion on post acute services plus hospice, which represents about 14 percent of total Medicare spending. MedPAC is concerned about the post-acute care received by Medicare beneficiaries. Let me be clear. There are many, many outstanding individual providers of those services. We fear, however, that we lack an integrated system that helps assure high-quality appropriate care at a reasonable cost. MedPAC sees five types of problems with the post-acute care system. First of all, we lack clear criteria on which setting is most appropriate for a given patient with a particular set of needs. This is not an easy problem to solve, especially given the varying and changing capabilities of different types of providers. Not all SNFs, for example, have the same capabilities. Given the wide variation and rates, which Chairman Johnson highlighted in her opening statement, to the widely different rates we pay different types of post acute providers, there is clearly great potential for waste, such as if a patient being unnecessarily sent to a high-cost type of institution: a LTCH or IRF, for example. On the other hand, there is also great potential for harm if a complex patient is sent to a facility that lacks the necessary capabilities.

A second set of problems with the post acute sector is that, within a given sector, for example SNFs, payments may not be properly adjusted for the mix of patients served at a particular institution. This is definitely an issue, we think, for SNFs, and quite possibly also an issue in the home health Prospective Payment System (PPS) as well. A third issue is that we currently don't adjust any of the payments for the quality of care provided, which we think is an important thing to do across all of the Medicare payment systems. Fourth, we don't collect the data necessary to be able to compare performance across post acute settings. In some cases we don't even collect the data necessary to judge performance within that particular setting of post-acute care. Finally, in at least the case of home health agencies and SNFs, MedPAC believes that current payments are high relative to the costs incurred in treating Medicare patients.

We see three broad potential strategies for improvement. One is to continue to refine the individual existing payment systems and establish criteria to guide placement of patients; in particular,

which patients require LTCH services or IRF services, the most expensive facilities. A second strategy, which may be in addition to the first, would be to give a case manager responsibility for guiding the placement decision, coupled with performance incentives. This would be a concept similar to what is being piloted in the case of disease management. Still a third strategy would be to create a post-acute care capitation payment whereby the dollars are bundled together. Unlike option two, here the party assigned responsibility would have risk for the utilization of services and not just for meeting performance standards. Now, these are very crude types, and there may well be other models, and there are certainly many variations on the basic themes. To this point, MedPAC has been focused on the first model, which is refinement of the existing individual payments systems. At least some of us are concerned that a rule-based approach to proper placement may be simultaneously both too complex and too crude.

The second and third options, which involve someone exercising judgment on the scene by introducing human judgment, could help deal with decisions since often the decision is influenced by the capabilities of the local providers. In some communities it may be appropriate to send a particular patient to an SNF that has unusual capabilities as opposed to an IRF or an LTCH. Having that human judgment involved could be helpful. The case manager approach or the capitation approach raises a host of complicated issues that MedPAC hasn't begun to explore in detail. Whichever path we choose, MedPAC believes that we also need to move forward with a common assessment tool. As discussed in our June report, the current tools used in home health agencies, SNFs, and IRFs do not collect data that can be compared across the payment silos and the different types of providers. In some instances we are not even collecting the data that we need to judge performance within a given sector. Thank you very much. I look forward to your questions.

[The prepared statement of Mr. Hackbarth follows:]

**Statement of Glenn M. Hackbarth, Chairman, Medicare Payment  
Advisory Commission**

Chairman Johnson, Ranking Member Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss post-acute care (PAC) payment issues in Medicare.

**Introduction**

Medicare beneficiaries can seek care after a hospitalization in four different post-acute settings: skilled nursing facilities (SNFs), home health agencies (HHAs), long-term care hospitals (LTCHs), and inpatient rehabilitation facilities (IRFs). Many factors influence Medicare beneficiaries' use of these services. For example, use of home health and SNF services grew rapidly after the introduction of the inpatient prospective payment system (PPS) in 1982. That payment system created an incentive for hospitals to discharge patients earlier. One strategy for doing so was to provide in a separate setting some of the recuperation and rehabilitation services that may have been formerly provided within the hospital stay. In the ensuing years, the four different post-acute settings have emerged to provide those recuperation and rehabilitation services. (A fifth type of service, hospice, overlaps somewhat with post-acute services in terms of patients and some services, although the goal is not recovery or rehabilitation.)

The overarching issue in PAC is that there are no clear and comprehensive criteria for which of these settings are best for patients with particular characteristics or needs. The recuperation and rehabilitation services provided are important for Medicare beneficiaries. Yet, these settings and their payment systems have devel-

oped separately over the years, and it is not clear that together they form an integrated whole that provides the highest quality, most appropriate care for beneficiaries or the best value for the Medicare program and the taxpayers who support it. Indeed, some parts of the country do not have all of these settings, yet Medicare patients are still receiving PAC services in those areas. A second issue is that within the SNF and home health settings payments are not well calibrated to patients and their conditions.

The Commission maintains that in the post-acute care sector, just as for the other sectors of Medicare, the services provided should meet the needs of the beneficiaries, Medicare payments should cover the costs of an efficient provider of those services, and higher quality services should be rewarded. Currently in post-acute care, none of these conditions is fully satisfied. The Commission has made recommendations for improving the payment systems for several of these sectors. It has recommended:

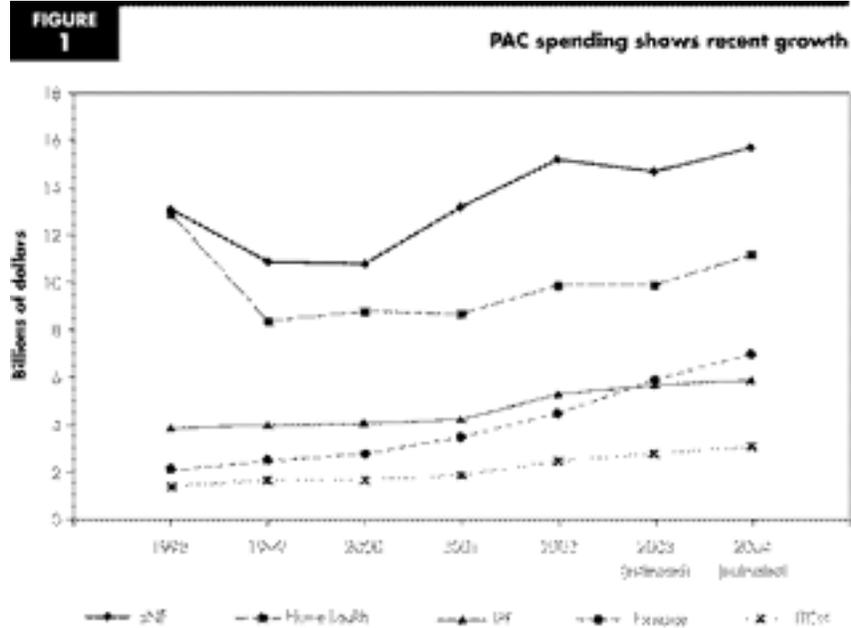
- Reforming the PPS for SNFs because the current system does not pay accurately for all of its patients and encourages providing rehabilitation services at the expense of caring for patients who have medically complex conditions.
- Reexamining the home health PPS because the services now provided are different than those provided when the system was created and payments may not be accurate.
- Creating facility level criteria to better define 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.

Finally, the Commission has recommended zero updates for both SNF and home health because Medicare overpays these sectors overall. Over payment makes it even more difficult to determine where cost effective services are available, in addition to placing unnecessary burdens on taxpayers and beneficiaries.

However, even if the payment systems were improved as we have recommended, there would still be 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. We discuss later in this testimony patient assessment instruments, which could contribute to evaluating outcomes and quality. Further efforts will be needed to assure that payments are balanced across and within settings and, more importantly, that patients go to the best setting for their conditions. In the longer term, a seamless PAC sector—with uniform assessments and payment tied to patients, their conditions, and their outcomes—could provide better care for beneficiaries and better value for the Medicare program.

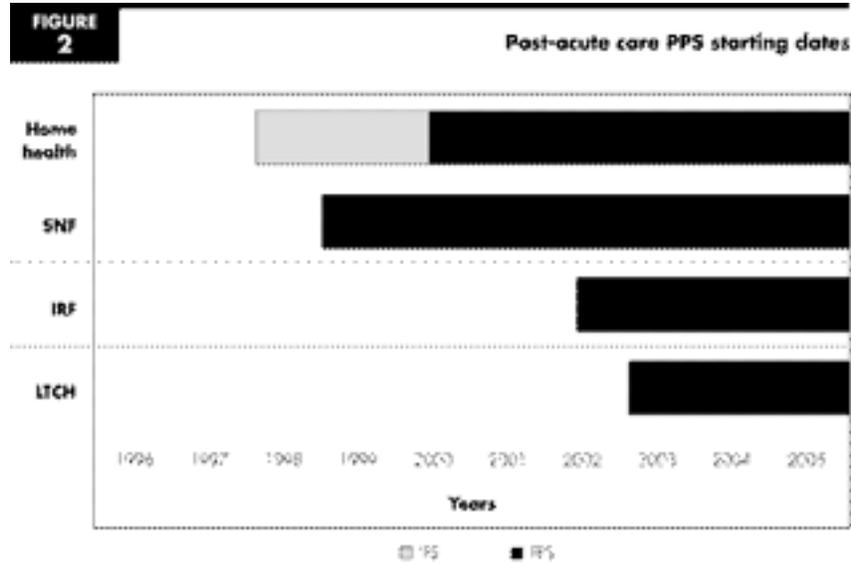
### **Background**

Altogether, Medicare spending on PAC services and hospice totaled about \$43 billion in 2004, accounting for about 14 percent of total Medicare spending. As shown in figure 1, spending has been growing rapidly in the last few years. Overall spending has increased by over 50 percent since 2000, with hospice spending increasing by 150 percent and long-term care hospitals spending by about 80 percent. The number of providers has grown as well. Home health agencies increased by 10 percent in the last year alone, and there were over 50 percent more LTCHs in 2005 than in 2000. The increase in spending is the result of both higher payments and greater use. For example, SNF admissions and days increased by about 14 percent in 2002.



In 2002, about one third of Medicare beneficiaries discharged from PPS hospitals went to a post-acute care setting. About one third of those went to a SNF, one third to home health, and the remainder either to other or multiple settings. PAC use is not uniform either across or within diagnoses groups. For some conditions, few beneficiaries use PAC services. For other conditions, where beneficiaries commonly do use PAC services, some beneficiaries will not. This lack of uniformity complicates analyses of this sector.

During the last era of rapid growth in post-acute care, the Congress passed the Balanced Budget Act of 1997. That act required the establishment of prospective payment systems (PPSs) for most PAC settings in the hope of curbing the rapid increase in Medicare spending for post-acute services. Figure 2 shows the implementation dates for each of the new PPSs.



As these payment systems have been implemented, and as providers have in turn reacted to the payment systems, some of the strengths and weaknesses of the PPSs have become apparent. MedPAC's key findings and recommendations for three of the individual systems are discussed below, followed by a discussion of a cross-setting issue—the lack of comparable patient assessment instruments.

#### **Skilled nursing facilities**

Medicare payment levels for SNFs have been favorable. SNFs have received a full market basket update in both FY 2004 and 2005. In addition, SNFs received an additional update in FY 2004 to correct for past market basket projection errors since the implementation of the PPS. In the past two years, for the 90 percent of SNFs that are freestanding, margins have been in the double digits. This finding in conjunction with other factors such as access and growth in use of services have led the Commission to recommend zero updates for 2003, 2004, 2005, and 2006.

#### ***Problems with the SNF case mix system***

MedPAC has recommended that the SNF PPS should be reformed for two reasons: First, the case mix system does not adjust payments for the costs of certain services that tend to be higher for medically complex SNF patients. Second, the payment rate is determined, in part, by the amount of therapy provided rather than by patient characteristics that predict therapy needs.

#### ***Case mix adjustment***

Medicare pays SNFs a set amount for each day of care adjusted for the case mix of the patients. The SNF PPS case mix system, the resource utilization groups (RUG—III) system, adjusts payments for the services provided. However it does not properly adjust payments for one category of services—nontherapy ancillary services (NTAs), such as prescription drugs and respiratory therapy—that are more heavily used by medically complex SNF patients. The BBA required that Medicare's prospective payment for SNFs include payment for NTAs. In compliance with this mandate, CMS included the cost of NTAs as part of the total costs used to develop Medicare's SNF base payment rates. However, NTA costs were not used to develop the RUG—III case-mix indexes that adjust the base payment rates according to patients' resource use. Instead, the payment system distributes payments for NTAs using the weights that are used to allocate payment for nursing care. As a result, the payment system does not distribute payments for NTAs according to variation in expected NTA costs across different patient types and thus pays relatively too much for patients receiving therapy and relatively too little for medically complex patients.

*Payment based on therapy to be provided*

Another problem is that the SNF PPS is overly oriented to therapy and that it determines the payment rate based on the amount of therapy services the patient uses—or is expected to use—rather than on patient characteristics and clinical appropriateness. (Therapy includes physical therapy, speech therapy, and occupational therapy.) The system pays based on the number of therapy minutes per week. It pays a fixed rate for ranges of therapy minutes—45 to 149 minutes (low), 150 to 324 minutes (medium), 325 to 499 minutes (high), 500 to 719 minutes (very high), and more than 720 minutes (ultra high). A SNF simply has to estimate the amount of therapy a patient will receive to get payments for the first three categories for the first 14 days. Payments for the two highest categories require the therapy actually be provided.

This system creates two incentives: The first is to classify patients into a higher payment category even though the patient may not benefit from additional therapy. The second is to provide the fewest number of minutes in the highest achievable payment category because therapy times at the bottom of the categories have the lowest cost relative to revenue.

Several studies suggest that SNFs have responded to these two incentives. First, studies found that the proportion of residents receiving no rehabilitation therapy declined between 1997 and 2000. Second, at initial assessment, fewer patients were categorized into the low group where payments are lowest. More patients were grouped into the medium and high groups where payments are higher and estimated, not actual, therapy minutes are sufficient for categorization. (According to the GAO, providers report payments for these medium and high rehabilitation groups also had the highest payment relative to costs.) Fewer patients were grouped into the very high and ultra high groups in which therapy must be provided for payment to be received. Finally, consistent with incentives to provide minutes of therapy at the low end of the range for a given payment category, patients in the medium and high rehabilitation categories received at least 30 fewer minutes of therapy per week in 2001 than in 1999; half of the patients initially categorized into these two groups did not actually receive the minimum minutes to be classified into these groups.

As a result of this orientation of the payment system towards therapy, beneficiaries who do not need rehabilitation services but do need certain nontherapy ancillary services may experience delays in accessing SNF care because the Medicare payment rates for these services may not be aligned with their costs. MedPAC and the GAO have pointed out that the RUG—III classification system may not pay enough to cover the costs of patients who require nontherapy ancillary services, such as expensive drugs and ventilator care services. There is enough money in the payment system to pay more for the care of these medically complex patients; the money must be redistributed from the therapy categories, which requires that the case mix system be reformed, as we have recommended for the past two years. We have also recommended that CMS focus on developing and improving quality measures, including collecting necessary information, for skilled nursing facility patients, and that patients be assessed at discharge from SNFs.

CMS has described its reform of the SNF PPS in its proposed rule for the system issued in May. We are studying the proposed rule and will provide CMS and the Congress with our comments. We will be looking for reforms that will reorient the payment system as we have described, and thus provide accurate payment and ensure access to SNF care for medically complex patients.

**Home health**

The number of home health users and the amount of services they used grew rapidly in the early 1990s, prompting the creation of the home health PPS and other actions by the Secretary and Congress on integrity standards and eligibility. Margins for home health providers have been consistently high since the implementation of the PPS. Initially, agencies were slow to enter the market; however, in the past 12 months, the number of agencies grew by more than 10 percent. CBO projects annual double-digit growth in spending in the next five years. In recognition of the high margins and other factors, MedPAC recommended a zero update for 2004, 2005, and 2006.

A source of concern for some policymakers has been that the number of home health users fell by about one million in the years preceding the implementation of the PPS. We do not find that this concern is justified. Our study found that the greatest decreases in use occurred among beneficiaries with the lowest predicted need for home health service, that the areas with the highest use of services (pre-PPS) had the greatest declines, and that beneficiaries eligible for both Medicaid and Medicare were not affected disproportionately.

Any decrease in use of home health services does not appear to be from lack of access to home health agencies. In 2003 and 2004, almost all beneficiaries (99 percent) lived in an area that was served by at least one home health agency. Nearly 90 percent of beneficiaries who responded to a CMS survey about their experience in 2003 said they had “little or no problem” accessing services. We found that rural beneficiaries reported even better access to care than their urban counterparts.

The home health PPS has moved the payment system from cost-based reimbursement and introduced an episode-based payment. While this has encouraged the provision of efficient care, the PPS has its shortcomings as well. The home health product has changed considerably since the current PPS was designed. Quality has improved, yet episodes now contain fewer visits, and the share of therapy and home health aide visits has shifted towards therapy. The case mix system should be revisited to make sure it corresponds with the new home health product. We have found that minutes of service per episode (and hence costs) may vary widely within the current case mix groups, and that some patient characteristics that are associated with cost variation are not now included in the case-mix adjustment.

The Commission has determined that Medicare should pay for higher quality to encourage better care for beneficiaries and better value for Medicare. It has also determined that the home health sector is ready to be paid for quality performance. The sector has a set of well-accepted, valid measures of the quality of outcomes of care. This measure set is currently collected by CMS from all agencies; it does not present an additional data burden. Quality has shown small improvements since the implementation of the PPS, but there is room for further improvement. Moving toward pay for performance has a special benefit in this setting because the product is not well-defined. By attaching dollars to outcomes, the program can purchase what it seeks—improvement in physical functioning or healing for wounds for example—rather than units of services with largely unknown content.

#### **Long-term care hospitals**

Long-term care hospitals are licensed as hospitals and are intended to treat medically complex patients. Medicare’s only additional requirement is that the average Medicare length of stay be more than 25 days. (The average length of stay in hospitals under the Medicare inpatient PPS is approximately 5 days.) The number of these facilities has been growing rapidly—at a 12 percent annual rate since 1993. Medicare spending for LTCHs has been growing even more rapidly—five fold from \$398 million in 1993 to \$1.9 billion in 2001; and Medicare is the predominant payer. LTCHs are also usually the most costly post-acute care setting.

In our June 2004 report, we found that in general LTCH patients cost Medicare more than similar patients using alternative settings; but for patients with the highest severity, the cost is comparable. We concluded that the growth in LTCHs may be due in part to the financial incentives in other Medicare payment systems. Hospitals under the inpatient PPS may want to transfer patients who are stable but have unresolved underlying complex medical conditions—for example, patients needing ventilator support for respiratory problems—because of the fixed payments in that system and the high costs of those patients. SNFs may find it less profitable to admit these patients than less complex patients because of the shortcomings in the SNF PPS we described earlier. These considerations make a new, clearer definition of LTCH care imperative. Therefore, we recommended that the Congress and the Secretary should define LTCHs by facility and patient criteria that ensure the patients admitted to these facilities are medically complex and have a good chance for improvement. Facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics (such as open wounds), and treatment modalities such as need for frequent intravenous fluid or medication.

We also recommended that the Secretary require the quality improvement organizations to review LTCH admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.

#### **Cross-setting issue: Patient assessment instruments**

Patient assessment tools should help providers assess patients’ care needs and evaluate the quality of care and patient outcomes. While Medicare requires three of the post-acute settings to use patient assessment tools, each uses a different one. SNFs use the minimum data set (MDS); HHAs the Outcome and Assessment Information Set (OASIS); and IRFs the IRF–Patient Assessment Instrument (IRF–PAI). LTCHs are not required to have a patient assessment tool. Uniform information would allow comparisons to be made across post-acute settings and provide an opportunity to assess cost, quality, outcomes and patient placement.

We found that although the tools measure the same broad aspects of patient care—functional status, diagnoses, comorbidities, and cognitive status—the timeframes covered, the scales used to differentiate patients, and the definitions of the care included in the measures vary considerably. These differences make it very difficult, if not impossible, to compare the quality of care and patient outcomes across all settings.

The tools vary substantially in how frequently clinicians must administer them, how long the assessments take to complete, and what time period the assessment covers. For example, the MDS is conducted close to (but not necessarily at) admission and periodically throughout the patient's stay (but not at discharge); generally asks about the patient's condition over the past 7 days; and takes about 90 minutes to complete. In contrast, the IRF-PAI is typically administered on day 3 of the admission and at discharge, captures the patient's status on that day, and is much shorter (taking about 25 minutes). As a result, it is impossible to evaluate whether differing assessment information truly reflects differences in the patients' condition, or just when the assessment was conducted, or the time period covered by the evaluation.

Further limiting the comparison of information gathered from the instruments is that even for the common aspects of patient care, the definitions of the measures are different. For example:

- Functional status: The MDS evaluates whether and how frequently the patient needed weight bearing or verbal encouragement to walk; the OASIS records a patient's ability to walk safely, once in a standing position; and the IRF-PAI includes the distances walked.
- Cognitive status: These measures and definitions varied the most across the three tools—including whether the tools distinguished between short versus long-term memory; how depression and delirium were evaluated; and the types of decisions patients are able to make.
- Diagnoses and comorbidities: Although these measures are generally considered straightforward to compare, the tools lack consistency in how this information is recorded. The MDS does not use ICD-9 codes to record diagnoses or comorbidities and the OASIS does not require the use of all 5 digits of the ICD-9 code, limiting the comparisons of the severity of patients treated in different settings.

Finally, even for measures where the definitions are the same, the instruments use varying scales and can measure different aspects of a task (such as independence) to differentiate patients. For example, the MDS uses a four-point scale and measures the number of times a patient needs assistance with dressing and the type of help involved (weight bearing or verbal encouragement), whereas the IRF-PAI uses a seven-point scale to distinguish what share of the dressing a patient performs.

### **Conclusion**

Ideally, the program would use a uniform patient assessment tool to assess whether a patient can go home safely or which post-acute setting would be most appropriate, and outcomes and quality would be measured over subsequent assessments. The PPS for each setting would then match payments to the cost of an efficient provider, and quality care would be rewarded. Medicare post-acute care is far from this ideal state. The Commission has made recommendations to improve payment systems in the individual settings and to bring quality into Medicare payment; but these recommendations have not yet been acted upon. In addition, a uniform patient assessment tool is still elusive. Developing a common instrument will be complex, even if it can build on some aspects of the current tools. The longer term goal is a seamless PAC sector—with uniform assessments and payment tied to patients, their conditions, and their outcomes.

Until a common instrument becomes available, we will investigate other approaches for improving post-acute care for Medicare beneficiaries. One approach could be to specify admission criteria for each setting, as we have recommended for long-term care hospitals. A different approach would concentrate on developing a “front-end” assessment tool to be administered prior to either discharge from the hospital or admission to a PAC setting on a physician's referral. Alternatively, care coordination by a case manager for post-acute care may be feasible. This approach could be modeled on CMS's chronic care improvement program with case managers assuming risk for achieving savings and quality targets.

The Commission will continue to inform the Congress as it deliberates on these issues. MedPAC will also continue to make recommendations to improve the incentives in the payment systems and the tools that support getting Medicare bene-

ficiaries to the post-acute care setting that is right for them—with the objective of getting the best care for beneficiaries and the best value for the Medicare program.

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Chairman JOHNSON. Thank you very much for your thoughtful comments. Dr. Kanof?

**STATEMENT OF MARJORIE KANOF, M.D., MANAGING DIRECTOR, HEALTH, U.S. GOVERNMENT ACCOUNTABILITY OFFICE**

Dr. KANOF. Madam Chairman, Congressman Lewis, and Members of the Subcommittee, good afternoon. I appreciate the opportunity to be here today to discuss our report issued in April, entitled “Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities.” Because patients treated at IRFs require more intensive rehabilitation than is provided in other settings such as SNFs, Medicare pays for treatment at IRFs at a higher rate than it pays for treatment in other settings. This difference in payment can be substantial, so we need to make sure that IRFs are correctly classified, and only patients whose needs are best met in an IRF should be admitted. To distinguish IRFs from other settings for payment purposes and to ensure that Medicare patients needing less intensive services are not in IRFs, CMS relies on a regulation commonly known as the 75 percent rule, which states that if a facility can show during a previous 12-month period that at least 75 percent of all its patients, including its Medicare patients, require intensive rehabilitation services for the treatment of at least 1 of 13 conditions listed in a rule, it may be classified as an IRF. The rule allows the remaining 25 percent of patients to have other conditions not listed in the rule. Before admitting a patient, an IRF is required to assess the patient to ensure they require the level of service provided, and CMS is responsible for evaluating the appropriateness of individual admissions, after the patient has been discharged, through medical reviews conducted by fiscal intermediaries. Three days after admission, IRFs are required to complete a patient assessment instrument that is used to determine Medicare payment.

Our report shows that there are Medicare patients in IRFs who might not need the level of care. In fiscal year 2003, fewer than half of all Medicare patients were admitted for having a primary condition on the list in the 75 percent rule. Almost half of all the patients with the conditions not on the list were admitted for orthopedic conditions, and among those the largest group was joint replacement patients. We found that relatively few of the Medicare unilateral joint replacement patients had a co-morbidity that needed IRF level of service. In fact, more than three-quarters of the patients that were admitted with a single joint replacement had no co-morbidities. Experts that we spoke with, including those that the Institute of Medicine (IOM) convened, told us that uncomplicated unilateral joint replacement patients rarely need to be admitted to an IRF. Our study also found that IRFs varied in the criteria that they used to assess patients for possible admissions. All IRFs evaluated a patient’s function, and half of them stated that function was the main factor that should be considered in assessing the need for IRF service. The assessment, however, did not determine

if any other setting besides an IRF was the appropriate site for the patient's care.

The experts IOM convened questioned the strength of the evidence for adding additional conditions to the list in the rule. They found the evidence for certain orthopedic conditions particularly weak, and some of them reported that there was little evidence available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology patients. They called for further research to identify the types of patients that needed inpatient rehabilitation and, more importantly, to understand the effectiveness of receiving treatment within an IRF as opposed to other settings. In addition, there was general agreement among all the experts we interviewed that diagnosis alone is insufficient for identifying appropriate types of patients for inpatient rehabilitation, because with any condition such as a stroke, only a subgroup of patients require the level of services that are needed in an IRF. Other factors such as function should be considered in addition to condition. As we concluded in our report, if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list. We recommended that CMS take several actions, including targeted reviews for medical necessity, and to more clearly define subgroups of patients within a condition that are appropriate for admission to IRFs, possibly using functional status or other factors in addition to condition. These actions could help to ensure that Medicare does not pay IRFs for patients who could be treated in a less intensive setting and does not misclassify facilities for payment. Madam Chairman, this concludes my statement.

[The prepared statement of Dr. Kanof follows:]

**Statement of Marjorie Kanof, M.D., Managing Director, Health,  
U.S. Government Accountability Office**

**MEDICARE**

**More Specific Criteria Needed to Classify Inpatient Rehabilitation  
Facilities**

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our report entitled *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities*,<sup>1</sup> which was issued in April 2005. Over the past decade, both the number of inpatient rehabilitation facilities (IRF)<sup>2</sup> and Medicare payments to these facilities have grown steadily. In 2003, there were about 1,200 such facilities. Medicare payments to IRFs grew from \$2.8 billion in 1992 to an estimated \$5.7 billion 2003 and are projected to grow to almost \$9 billion per year by 2015.

Because patients treated at IRFs require more intensive rehabilitation than is provided in other settings, such as an acute care hospital or a skilled nursing facility (SNF),<sup>3</sup> Medicare pays for treatment at an IRF at a higher rate than it pays for treatment in other settings. The difference in payment to IRFs and other set-

<sup>1</sup> See GAO, Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities, GAO-05-366 (Washington, D.C.: Apr. 22, 2005).

<sup>2</sup> IRFs are intended to serve patients recovering from medical conditions that require an intensive level of rehabilitation. Not all patients with a given condition may require the level of rehabilitation provided in an IRF. For example, although a subset of patients who have had a stroke may require the intensive level of care provided by an IRF, others may be less severely disabled and require less intensive services.

<sup>3</sup> In addition to IRFs, acute care hospitals, and SNFs, other settings that provide rehabilitation services include long-term-care hospitals, outpatient rehabilitation facilities, and home health care.

tings can be substantial, and so IRFs need to be correctly classified to be distinguished from other settings in which less intensive rehabilitation is provided.

To distinguish IRFs from other settings for payment purposes and to ensure that Medicare patients needing less intensive services are not in IRFs, the Centers for Medicare & Medicaid Services (CMS) relies on a regulation commonly known as the “75 percent rule.”<sup>4</sup> This rule states that if a facility can show that during a 12-month period at least 75 percent of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of at least 1 of the 13 conditions listed in the rule,<sup>5</sup> it may be classified as an IRF. The rule allows the remaining 25 percent of patients to have other conditions not listed in the rule. IRFs are required to assess patients prior to admission to ensure they require the level of services provided in an IRF, and CMS is responsible for evaluating the appropriateness of individual admissions after the patient has been discharged through reviews for medical necessity conducted under contract by its fiscal intermediaries.<sup>6</sup> An IRF that does not comply with the requirements of the 75 percent rule may lose its classification as an IRF and therefore no longer be eligible for payment by Medicare at a higher rate.<sup>7</sup>

IRF compliance with the rule has been problematic, and some IRFs have questioned the requirements of the rule. CMS data indicate that in 2002 only 13 percent of IRFs had at least 75 percent of patients in 1 of the 10 conditions on the list at that time. IRF officials have contended that the list of conditions in the rule should be updated because of changes in medicine that have occurred and the concomitant expansion of the population that could benefit from inpatient rehabilitation services.

The Conference Report that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed us to issue a report, in consultation with experts in the field of physical medicine and rehabilitation, to assess whether the current list of conditions represents a clinically appropriate standard for defining IRF services and, if not, to determine which additional conditions should be added to the list.<sup>8</sup> In this testimony, I will discuss our April 2005 report, in which we (1) identified the conditions—on and off the list—that IRF Medicare patients have and the number of IRFs that meet the requirements of the 75 percent rule; (2) described how IRFs assess patients for admission and whether CMS reviews admission decisions; and (3) evaluated the approach of using a list of conditions in the 75 percent rule to classify IRFs.

In carrying out our work, we analyzed data from the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF–PAI) records on all Medicare patients (the majority of patients in IRFs) admitted to IRFs in fiscal year 2003<sup>9</sup> (the most recent data available at the time). The IRF–PAI records contain, for each Medicare patient, the impairment group code<sup>10</sup> identifying the patient’s primary condition and the diagnostic code from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) identifying the patient’s comorbid condition (if any).<sup>11</sup> We used these codes to determine whether we considered the patient’s

<sup>4</sup> See 42 U.S.C. § 1395ww(d)(1)(B) (2000). The 75 percent rule was initially issued in 1983 and most recently revised in 2004. See 42 C.F.R. § 412.23(b)(2) (2004).

<sup>5</sup> For an annotated list of these conditions, see appendix I.

<sup>6</sup> Fiscal intermediaries are contractors to CMS that verify compliance with the rule and conduct reviews for medical necessity to determine whether an individual admission to an IRF is covered under Medicare.

<sup>7</sup> In addition to the 75 percent rule, an IRF must meet six regulatory criteria showing that it had (1) a Medicare provider agreement; (2) a preadmission screening procedure; (3) medical, nursing, and therapy services; (4) a plan of treatment for each patient; (5) a coordinated multidisciplinary team approach; and (6) a medical director of rehabilitation with specified training or experience. IRFs must also meet other criteria identified in 42 C.F.R. § 412.22 (2004) and 42 C.F.R. § 412.25 (2004).

<sup>8</sup> See H.R. Rep. 108–391, at 649 (2003).

<sup>9</sup> We analyzed the 2003 data using the 13 conditions in the current regulation even though in fiscal year 2003 there were 10 conditions on the list. Effective July 1, 2004, the number of conditions increased from 10 to 13.

<sup>10</sup> The impairment group code identifies the medical condition that caused the patient to be admitted to an IRF, and its sole function is to determine payment rates. As a result, the impairment group codes describe every patient in an IRF and include medical conditions that are on the list in the rule as well as those that are not on the list since IRFs may treat patients with conditions not on the list. In contrast, the list of conditions in the rule describes the patient population that is to be treated in an IRF to ensure that a facility is appropriately classified to justify payment for the level of services furnished.

<sup>11</sup> As used in this report, a primary condition is the first or foremost medical condition for which the patient was admitted to an IRF, and other medical conditions may coexist in the patient as comorbid conditions, or comorbidities.

primary or comorbid condition to be linked to a condition on the list in the rule.<sup>12</sup> We also spoke to 12 IRF medical directors, 10 fiscal intermediary officials, and contracted with the Institute of Medicine (IOM) of the National Academies to convene a 1-day meeting of 14 clinical experts in physical medicine and rehabilitation to evaluate the approach of using a list of conditions in the 75 percent rule. We conducted our work from May 2004 through April 2005 in accordance with generally accepted government auditing standards.

In brief, as noted in the report, in fiscal year 2003 fewer than half of all IRF Medicare patients were admitted for having a primary condition on the list in the 75 percent rule. Almost half of all patients with conditions not on the list were admitted for orthopedic conditions, and among those the largest group was joint replacement patients. The experts IOM convened told us that uncomplicated unilateral joint replacement patients rarely need to be admitted to an IRF, and our analysis suggested that relatively few of the Medicare unilateral joint replacement patients had comorbid conditions that suggested a possible need for the IRF level of services. Additionally, we found that only 6 percent of IRFs in fiscal year 2003 were able to meet a 75 percent threshold. We also found that IRFs varied in the criteria used to assess patients for admission, using patient characteristics such as functional status, as well as condition. We noted that CMS, working through its fiscal intermediaries, had not routinely reviewed IRF admission decisions to determine whether they were medically justified, although it reported that such reviews could be used to target problem areas. The experts IOM convened and other clinical and nonclinical experts we interviewed differed on whether conditions should be added to the list in the 75 percent rule. The experts IOM convened questioned the strength of the evidence for adding conditions to the list—finding the evidence for certain orthopedic conditions particularly weak—and some of them reported that little information was available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology patients. They called for further research to identify the types of patients that need inpatient rehabilitation and to understand the effectiveness of IRFs. There was general agreement among all the groups of experts we interviewed that condition alone is insufficient for identifying appropriate types of patients for inpatient rehabilitation, since within any condition only a subgroup of patients require the level of services of an IRF, and that functional status should also be considered in addition to condition.

We concluded that if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list at the present time and the rule should be refined to clarify which types of patients should be in IRFs as opposed to another setting. As noted in the report, we recommended that CMS ensure that targeted reviews for medical necessity are conducted for IRF admissions; conduct additional activities to encourage research on IRFs; and refine the 75 percent rule to more clearly describe the subgroups of patients within a condition that are appropriate for IRFs, possibly using functional status or other factors in addition to condition. CMS generally agreed with our recommendations.

### **Background**

The 75 percent rule was established in 1983 to distinguish IRFs from other facilities for payment purposes. According to CMS, the conditions on the list in the rule at that time accounted for 75 percent of the admissions to IRFs. In June 2002 CMS suspended the enforcement of the 75 percent rule after its study of the fiscal intermediaries revealed that they were using inconsistent methods to determine whether an IRF was in compliance and that in some cases IRFs were not being reviewed for compliance at all. CMS standardized the verification process that the fiscal intermediaries were to use, and issued a rule—effective July 1, 2004—that increased the number of conditions from 10 to 13 and provided a 3-year transition period, ending in July 2007, to phase in the 75 percent threshold.<sup>13</sup>

The current payment and review procedures for IRFs were established in recent years. The inpatient rehabilitation facility prospective payment system (IRF PPS)

<sup>12</sup>Throughout this testimony, the “list in the rule” refers to the list of 13 conditions as specified in the 2004 75 percent rule, and when we say that condition is on (or off) the list, we mean that we have (or have not) been able to link the condition as identified in the patient assessment record to a condition on the list in the rule.

<sup>13</sup>During the transition period, the threshold increases each year (from 50 percent to 60 percent to 65 percent) before the 75 percent threshold is effective. The transition period also allows a patient to be counted toward the required threshold if the patient is admitted for either a primary or comorbid condition on the list in the rule. At the end of the transition period, a patient cannot be counted toward the required threshold on the basis of a comorbidity on the list in the rule.

was implemented in January 2002. Payment is contingent on an IRF's completing the IRF-PAI after admission and transmitting the resulting data to CMS. Two basic requirements must be met if inpatient hospital stays for rehabilitation services are to be covered: (1) the services must be reasonable and necessary, and (2) it must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility, such as a SNF, or on an outpatient basis.<sup>14</sup> Determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Beginning in April 2002, the fiscal intermediaries, the entities that conduct compliance reviews, were specifically authorized to conduct reviews for medical necessity to determine whether an individual admission to an IRF was covered under Medicare.<sup>15</sup>

**Fewer Than Half of All IRF Medicare Patients in 2003 Were Admitted for Conditions on List in Rule, and Few IRFs Were Able to Meet a 75 Percent Threshold**

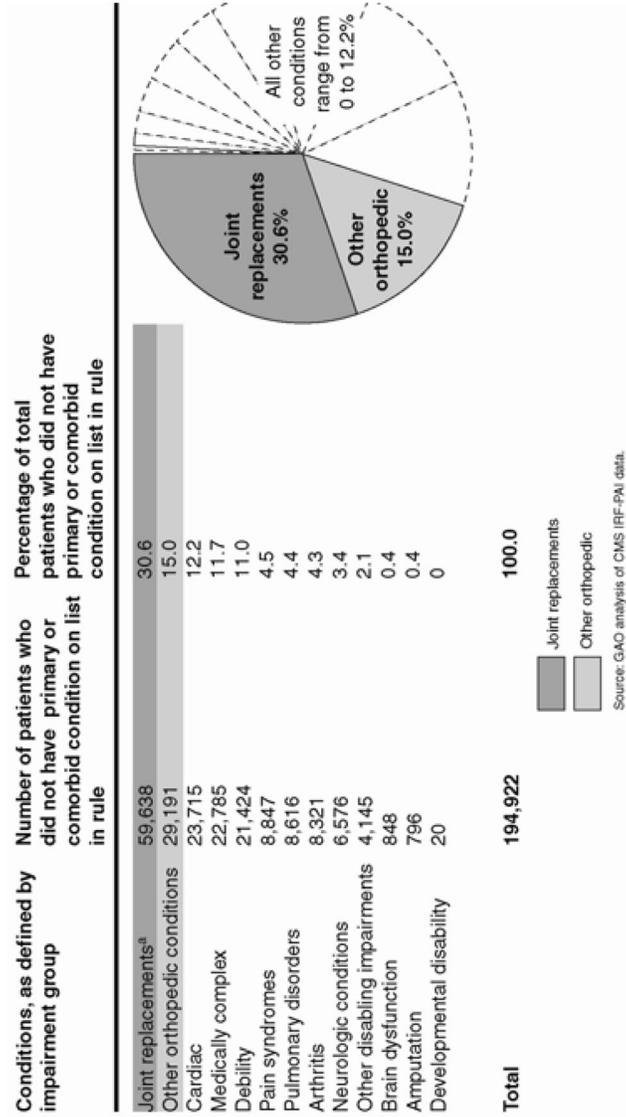
As we reported in April 2005, among the 506,662 Medicare patients admitted to an IRF in fiscal year 2003, less than 44 percent were admitted with a primary condition on the list in the 75 percent rule. About another 18 percent of IRF Medicare patients were admitted with a comorbid condition that was on the list in the rule. Among the 194,922 IRF Medicare patients that did not have a primary or comorbid condition on the list in the rule, almost half were admitted for orthopedic conditions, and among those the largest group was joint replacement patients whose condition did not meet the list's specific criteria. (See figure 1.)

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<sup>14</sup> Rehabilitative care in a hospital, rather than a SNF or on an outpatient basis, is considered to be reasonable and necessary when a patient requires a more coordinated, intensive program of multiple services than is generally found outside of a hospital (Medicare Benefit Policy Manual, chapter 1, Section 110.1).

<sup>15</sup> Prior to this time, Quality Improvement Organizations had this authority. CMS Transmittal 21 made clear that fiscal intermediaries have the authority to review admissions to IRFs.

**Figure 1: Distribution of IRF Medicare Patients Who Did Not Have Condition on List in Rule, by Condition as Defined by Impairment Group, Fiscal Year 2003**



<sup>a</sup>Includes joint replacement patients who had a unilateral procedure and those who were under age 85 and therefore did not meet two of the three specific criteria for joint replacements set out in the 75 percent rule. (See app. I.) Codes from CMS for the third criterion—body mass index—were not available.

Although some joint replacement patients may need admission to an IRF, such as those with comorbidities that affect the patient’s function, our analysis showed that few of these patients had comorbidities that suggested a possible need for the level of services offered by an IRF. Our analysis found that 87 percent of joint replacement patients admitted to IRFs in fiscal year 2003 did not meet the criteria of the rule, and among those, over 84 percent did not have any comorbidities that would have affected the costs of their care based on our analysis of the payment data.

Because the data we analyzed were from 2003, when enforcement of the rule was suspended, we also looked at newly released data from July through December 2004, after enforcement had resumed, to determine whether admission patterns had changed. We focused on the largest category of patients admitted to IRFs, joint replacement patients, and found no material change in the admission of joint replace-

ment patients for the same time periods in 2003 and 2004. Across all IRFs, the percentage of Medicare patients admitted for a joint replacement declined by 0.1 percentage point.

In conjunction with our finding on the number of patients admitted to IRFs for conditions not on the list in the rule, we determined that only 6 percent of IRFs in fiscal year 2003 were able to meet a 75 percent threshold. Many IRFs were able to meet the lower thresholds that would be in place early in the transition period, but progressively fewer IRFs were able to meet the higher threshold levels.

#### **IRFs Vary in the Criteria Used to Assess Patients for Admission, and CMS Does Not Routinely Review IRFs' Admission Decisions**

As we stated in our report, the criteria IRFs used to assess patients for admission varied by facility and included patient characteristics in addition to condition. All the IRF officials we interviewed evaluated a patient's function when assessing whether a patient needed the level of services of an IRF. Whereas some IRF officials reported that they used function to characterize patients who were appropriate for admission (e.g., patients with a potential for functional improvement), others said they used function to characterize patients not appropriate for admission (e.g., patients whose functional level was too high, indicating that they could go home, or too low, indicating that they needed to be in a SNF). Almost half of the IRF officials interviewed stated that function was the main factor that should be considered in assessing the need for IRF services.

IRF officials reported to us that they did not admit all the patients they assessed. Typically, the IRF received a request from a physician in the acute care hospital requesting a medical consultation from an IRF physician, or from a hospital discharge planner or social worker indicating that they had a potential patient. An IRF staff member—usually a physician and/or a nurse—conducted an assessment prior to admission to determine whether to admit a patient.

CMS, working through its fiscal intermediaries, has not routinely reviewed IRF admission decisions, although it reported that such reviews could be used to target problem areas. Among the 10 fiscal intermediary officials we interviewed, over half were not conducting reviews of patients admitted to IRFs. We concluded that the presence of patients in IRFs who may not need the intense level of services provided by IRFs called for increased scrutiny of IRF admissions, which could target problem areas and vulnerabilities and thereby reduce the number of inappropriate admissions in the future. We recommended that CMS ensure that its fiscal intermediaries routinely conduct targeted reviews for medical necessity for IRF admissions. CMS agreed that targeted reviews are necessary and said that it expected its contractors to direct their resources toward areas of risk. It also reported that it has expanded its efforts to provide greater oversight of IRF admissions through local policies that have been implemented or are being developed by the fiscal intermediaries.

#### **Experts Differed on Adding Conditions to List in Rule but Agreed That Condition Alone Does Not Provide Sufficient Criteria**

As we reported, the experts IOM convened and other experts we interviewed differed on whether conditions should be added to the list in the 75 percent rule but agreed that condition alone does not provide sufficient criteria to identify types of patients appropriate for IRFs.

The experts IOM convened generally questioned the strength of the evidence for adding conditions to the list in the rule. They reported that the evidence on the benefits of IRF services is variable, particularly for certain orthopedic conditions, and some of them reported that little information was available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology conditions. In general, they reported that, except for a few subpopulations, uncomplicated, unilateral joint replacement patients rarely need to be admitted to an IRF. Most of them called for further research to identify the types of patients that need inpatient rehabilitation and to understand the effectiveness of IRFs in comparison with other settings of care. IRF officials we interviewed did not agree on whether conditions, including a broader category of joint replacements, should be added to the list in the rule. Half of them suggested that joint replacement be more broadly defined to include more patients saying, for example, that the current requirements were too restrictive and arbitrary. Others said that unilateral joint replacement patients were not generally appropriate for IRFs. We recommended that CMS conduct additional activities to encourage research on the effectiveness of intensive inpatient rehabilitation and factors that predict patient need for these services. CMS agreed and said that it has expanded its activities to guide future research efforts by encouraging government research organizations, academic institutions, and the rehabilitation industry to con-

duct both general and targeted research, and plans to collaborate with the National Institutes of Health to determine how to best promote research.

There was general agreement among all the groups of experts we interviewed, including the experts IOM convened, that condition alone is insufficient for identifying appropriate types of patients for inpatient rehabilitation, because not all patients with a condition on the list need to be in an IRF. For example, stroke is on the list, but not all stroke patients need to go to an IRF after their hospitalization. Similarly, cardiac condition is not on the list, but some cardiac patients may need to be admitted to an IRF. Among the experts convened by IOM, functional status was identified most frequently as the information required in addition to condition. Half of them commented on the need to add information about functional status, such as functional need, functional decline, motor and cognitive function, and functional disability. However, some of the experts convened by IOM recognized the challenge of operationalizing a measure of function, and some experts questioned the ability of the current assessment tools to predict which types of patients will improve if treated in an IRF.<sup>16</sup>

We concluded that if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list at the present time, and that future efforts should refine the rule to increase its clarity about which types of patients are most appropriate for IRFs. We recommended that CMS use the information obtained from reviews for medical necessity, research activities, and other sources to refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors, in addition to condition. CMS stated that while it expected to follow our recommendation, it would need to give this action careful consideration because it could result in a more restrictive policy than the present regulations, and noted that future research could guide the agency's description of subgroups.

#### **Concluding Observations**

We stated in our report, we believe that action to conduct reviews for medical necessity and to produce more information about the effectiveness of inpatient rehabilitation could support future efforts to refine the rule over time to increase its clarity about which types of patients are most appropriate for IRFs. These actions could help to ensure that Medicare does not pay IRFs for patients who could be treated in a less intensive setting and does not misclassify facilities for payment.

Madam Chairman, this concludes my prepared statement. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

#### **Contact and Staff Acknowledgments**

For further information about this testimony, please contact Marjorie Kanof at (202) 512-7114. Linda Kohn and Roseanne Price also made key contributions to this statement.

#### **Appendix I: List of Conditions in CMS's 75 Percent Rule**

A facility may be classified as an IRF if it can show that, during a 12-month period<sup>17</sup> at least 75 percent of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of one or more of the following conditions:<sup>18</sup>

1. Stroke.
2. Spinal cord injury.
3. Congenital deformity.
4. Amputation.
5. Major multiple trauma.
6. Fracture of femur (hip fracture).
7. Brain injury.
8. Neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease).
9. Burns.
10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of

<sup>16</sup>For example, one fiscal intermediary official reported that the instrument that is currently used does not adequately measure progress in small increments, such as a quadriplegic patient might experience. Another respondent also reported that the current instrument only measures functional status at a point in time, but does not predict functional improvement.

<sup>17</sup>The time period is defined by CMS or the CMS contractor.

<sup>18</sup>See 42 C.F.R. § 412.23(b)(2)(iii) (2004).

ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
12. Severe or advanced osteoarthritis (osteoarthritis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)
13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:
  - a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
  - b. The patient is extremely obese, with a body mass index of at least 50 at the time of admission to the IRF.
  - c. The patient is age 85 or older at the time of admission to the IRF.

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Chairman JOHNSON. Thank you very much. Mr. Kuhn.

**STATEMENT OF HERB KUHN, DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. KUHN. Madam Chairman, Congressman Lewis, Members of the Subcommittee, thank you for inviting me here today to discuss ways to improve coordination in the payment and clinical assessment of post-acute care. A more beneficiary-centered system of post-acute care services has the potential to improve quality of care, access to care, and continuity of care in a cost efficient way. Post-acute care services are offered in SNFs and IRFs, in the home, and in LTCHs. Each of these settings has its own payment system and method for evaluation of patient functioning. The transition from cost-based reimbursement to the PPS in post-acute care was a major milestone for Medicare that resulted in improved cost containment, while more directly linking payments to the care needs of each beneficiary. However, since each of these systems was developed independently, it is time to consider ways of improving coordination and payment and clinical assessment across care settings to provide a more seamless system of post-acute care services. Today, Medicare's benefits and policies have focused on phases of a patient's illness as defined by specific site of service rather than

on the entire post-acute care episode. Thus, payments across settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar. Further, each patient assessment instrument collects somewhat different content and stores the patient's health and functional status information in different data formats which are often not compatible. Because of this variation, care may be disrupted when a Medicare patient moves across settings. We should focus on the actual patient need and eliminate the financial incentives for providers to transfer patients from one post-acute care setting to another based on financial considerations.

To do so, we should investigate a more coordinated approach to payment and delivery of post-acute care services that focuses on the overall post-acute care episode or attempts to pay more consistently across the different sites of care, an approach that relies on a single comprehensive assessment of a patient's needs and clinical characteristics that ensure that payments are at levels consistent with high quality cost-effective care, regardless of setting. The CMS has several initiatives in the planning and implementation phase to develop a more consistent payment and assessment structure in post-acute care. More specifically, we are working to study existing patient assessment instruments and potential for the future. We are also working with the National Quality Forum to set up a technical expert group to look at the development and the functional status framework to identify information we should be collecting on aspects of relevant functional status. Furthermore, we are mapping the Minimum Data Set (MDS), to Consolidated Health Informatics (CHI), to ensure the MDS conforms to CHI standards. In addition, CMS has twice expanded the post-acute care transfer policy under which it pays the acute hospital transferring a patient to a post-acute care setting under a per diem payment rather than the full Diagnosis Related Group (DRG) payment. In the most recent inpatient PPS notice of proposed rulemaking, CMS proposed to expand the policy even further.

MedPAC has commented on the challenges we face in coordinating our post-acute care payment methods, and suggested that it may be appropriate to explore additional options for reimbursing post-acute care services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods. In fact, we have recently issued proposed regulations for SNFs and IRFs in which we discuss the long-range possibilities for an integrated post-acute care payment structure. While we have not made any formal proposals, we have solicited comment on potential models from the industry and other stakeholders. The CMS is committed to a variety of activities to develop more consistent payment and assessment systems for post-acute care. We fully recognize and support the benefit of having a more comprehensive system where the incentives are to place the patient in the most appropriate post-acute care setting rather than a setting where the payment is most advantageous. Thank you again for the opportunity to speak to you today about the potential for increased payment accuracy and patient assessment standardization in post-acute care. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Kuhn follows:]

**Statement of Herb Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services**

**Introduction**

Madam Chairman Johnson, Congressman Stark, distinguished members of the subcommittee, thank you for inviting me here today to discuss ways to improve coordination in the payment and clinical assessment of post-acute care. A more beneficiary-centered system of post-acute care services has the potential to improve quality of care, access to care, and continuity of care in a cost efficient way.

CMS is committed to ensuring that our administrative actions provide maximum support to further steps toward higher quality post-acute care and we have numerous initiatives underway to further this goal. Medicare pays for rehabilitation and other post-acute care services in a variety of settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and home health. Adopting techniques that can provide greater uniformity in how patients are assessed and quality is measured can support efforts to pay more consistently for services across different sites of post-acute care while eliminating administrative barriers and incentives that impede high quality care. CMS is actively exploring such approaches as it works to improve its payment systems under Medicare while supporting quality and access.

**Background**

CMS began transitioning to the various post-acute care prospective payment systems (PPSs) in accordance with the Balanced Budget Act of 1997. The transition began with skilled nursing facilities in July of 1998, followed by rural swing beds SNFs in July of 2000, home health agencies (HHAs) in October of 2000, IRFs in January of 2002, LTCHs in October of 2002, and finally psychiatric hospitals in January of 2004. The new administrative pricing models have generated substantial improvements over the preexisting cost-based systems. Further, the transition from cost based reimbursement to PPS in post-acute care was a major milestone for the program that resulted in improved cost containment while more directly linking payments to the care needs of each beneficiary. However, since each of these systems was developed independently, it is time to consider ways of improving coordination of payment and clinical assessment across care settings to provide a more seamless system of post-acute care services.

To date, Medicare's benefits and policies have focused on phases of a patient's illness as defined by a specific site of service, rather than on the entire post-acute care episode. Thus, payments across settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar. As the differentiation among provider types becomes less pronounced, it may now be appropriate to explore more coordinated approaches to the payment and delivery of post-acute care services that focus on the overall post-acute episode. Initially such approaches would focus on establishing more consistent payments across different sites of service where services provided to patients and associated resource requirements are similar. Ultimately, we should focus our efforts on developing a system that provides payment and assures quality for the overall post-acute episode, rather than each individual component of the continuum of care. In order to accomplish these objectives, we need to begin to collect and compare consistent clinical data across various sites of service and use these data as part of our research efforts to build the components of such a system.

In the long run, our ability to compare clinical data across care settings is one of the benefits of standardized electronic health records (EHRs) and other steps to promote continuity of care across all settings. It is also important to recognize the complexity of the effort, not only in developing an integrated assessment tool that is designed using health information standards, but in examining the various provider-focused prospective payment methodologies and considering payment approaches that are based on patient characteristics and outcomes.

MedPAC has recently taken a preliminary look at the challenges in improving the coordination of our post-acute care payment methods, and suggested that it may be appropriate to explore additional options for reimbursing post-acute care services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods.

### **Post-Acute Care Settings**

Post-acute care services are offered in SNFs, in IRFs, in the home by HHAs, and in LTCHs. Each of these settings has its own payment system and method for evaluating patient functioning. Each of the current payments systems is described below.

#### **SNF Per Diem Payments Based on Resource Utilization Groups**

SNFs provide short-term skilled nursing and rehabilitative care to people with Medicare who require such services on a daily basis in an inpatient setting after a medically necessary hospital stay lasting at least three days. SNFs receive per diem payments for each admission, which are case-mix adjusted using a resident classification system, Resource Utilization Groups (RUG) III, based on data from resident assessments and relative weights developed from staff time data. SNFs use the MDS 2.0 instrument to assess care planning as part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. More specifically, patients are classified into RUG-III groups based on need for therapy (i.e., physical, occupational, or speech therapy), special treatments (e.g., tube feeding), and functional status (e.g., ability to feed self and use the toilet). Patient status is reviewed periodically to update the RUG-III grouping.

An interdisciplinary team completes the MDS via several sources, such as communicating with and observing the resident, reviewing the medical record, and communicating with family & staff. The assessment for a SNF patient is completed at a few intervals of his/her stay, on days 5, 14, 30, 60, & 90 day, although there are times when an off-cycle assessment may need to be completed. The 5-day assessment covers payment for days 1–14; 14-day for days 15–30; etc.

CMS requires that once the MDS is completed, it be submitted electronically to the State database. When the assessment is required for SNF payment, a Resource Utilization Group (RUG) is assigned to the assessment. The RUG assignment is based on specific items within the MDS. The RUG categories are based on time study data, which measured staff time for medical conditions, disease processes and treatment interventions. A provider may submit a claim to its FI once the assessment is submitted and accepted into the State database.

#### **Home Health 60-Day Episode Payments Based on National Rate**

To qualify for Medicare home health visits, people with Medicare must be under the care of a physician; have an intermittent need for skilled nursing care, or need physical therapy, speech therapy; or have a continuing need for occupational therapy; be homebound; and receive home health services from a Medicare approved home health agency. Under the PPS, Medicare pays higher rates to HHAs to care for those beneficiaries with greater needs. Home health is measured in 60-day units called episodes, and the amount of payment for an episode is thenational base rate, adjusted for case-mixand for prices in the area where thepatient resides. The base payment covers the costs of visits, to include the costs of routine and non-routine medical supplies, which is based upon a model with 1998 costs and updated annually using the home healthmarket basket.

Payment rates are based on relevant data from patient assessments using the Outcome and Assessment Information Set (OASIS). The OASIS is a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes used by CMS to determine appropriate case-mix adjustment for Medicare payment purposes and by individual agencies for outcome based quality improvement, or OBQI. Medicare Conditions of Participation (CoPs) for Home Health Agencies (HHAs) require that information about a patient's health status be collected by HHA staff using the OASIS assessment instrument at the start of care, at discharge or transfer, at follow up (60 day re-certification) and at resumption of care.

The purpose of case-mix adjustment, like the DRG system for hospitals, is to adjust payment based on the different levels of resources used for a unit of service. The home health case mix methodology uses a combination of scores from 23 OASIS items and an additional data element measuring the receipt of therapy services that result in one of 80 case mix weights or home health resource groups, which in turn determine the payment for the episode of care. These data elements are organized into three dimensions to capture clinical severity factors, functional severity factors, and service utilization factors influencing case-mix.

### **Inpatient Rehabilitation Facility (IRF) Per Discharge Payments Based on Case-Mix Groups**

For classification as an IRF, a percentage of the IRF's total inpatient population during the compliance review period that is associated with an IRF's cost reporting period must match one or more of thirteen specific medical conditions. Payments under the IRF PPS are made on a per discharge basis. Under this system, payment rates are based on case-mix groups (CMGs) that reflect the clinical characteristics of the patient and the anticipated resources that will be needed for treatment.

IRFs use the IRF Patient Assessment Instrument (IRF-PAI) to assess the functional performance and health status of the patient and changes in the patient's functional performance status from admission to discharge. Under IRF PPS, a person with Medicare must be assessed using the IRF-patient assessment instrument (PAI). The IRF-PAI is a three page form that captures demographic, medical, and functional performance data regarding the patient. Using the IRF-PAI, an IRF's clinicians assess the inpatient at both admission and discharge, and the combined data is electronically transmitted to CMS only once after the patient is discharged. Typically the admission assessment is performed during the first three calendar days of the patient's stay. The admission data that is recorded by the IRF's staff on the electronic version of the IRF-PAI results in the patient being automatically classified into one of the payment groups that are referred to as case-mix groups (CMGs). The IRF then records the CMG code on the Medicare claim. As the IRF's Medicare claim is processed by the fiscal intermediary both case level and facility level adjustments are automatically applied to the initial unadjusted CMG payment rate resulting in the adjusted payment amount that the IRF will receive for care furnished to the inpatient.

### **Long-Term Care Hospital (LTCH) Per Discharge Payments Based on Diagnosis Related Groups**

Long-term care hospitals have an average Medicare inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment, and pain management. The PPS for LTCHs classifies patients into distinct diagnostic groups based on clinical characteristics and expected resource needs (LTC-Diagnosis Related Groups (DRGs)), which are based on the existing CMS DRGs used under the acute hospital inpatient PPS that have been weighted to reflect the resources required to treat the medically complex patients treated at LTCHs.

Although LTCHs do not have a standard patient assessment tool, following a rigorous analysis of existing research on the universe of LTCHs and their typical patients, CMS has a contractor collecting information from several sources that could be used to develop patient-level criteria for LTCHs. There are three main types of data sources for this facet of the project: Claims analysis, Quality Improvement Organization interviews, and site visits/provider discussions. CMS expects to receive the final report on this research project from our contractor by the end of FY 2005.

### **CMS is taking Action toward Change**

CMS has several initiatives in the planning and implementation phases to further our goals of developing a more consistent payment and assessment structure in post-acute care. More specifically, we are working with our stakeholders to study existing patient assessment instruments and potential for the future. We are also working with the National Quality Forum (NQF) to set up a technical expert group to look at the development of a functional status framework to identify information we should be collecting on aspects of relevant functional status. Furthermore, we are mapping the MDS to Consolidated Health Information (CHI) to ensure the MDS conforms to CHI standards. In addition, CMS has twice expanded the post-acute transfer policy under which it pays the acute hospital transferring a patient to a post-acute setting under a per-diem payment, rather than the full DRG payment. In the most recently-proposed inpatient PPS Notice of Proposed Rulemaking, CMS proposed to expand the policy even further. Finally, we are currently evaluating CMS research priorities and anticipate funding future research to develop payment systems using clinical data collected across post-acute care settings.

### **CMS is Working in Coordination with out Stakeholders**

Beginning in 2001, CMS has been working collaboratively on an investigatory effort funded by Assistant Secretary for Planning and Evaluation (ASPE) to learn more about the current and potential future design of our patient assessment tools. More specifically, this effort was designed to hold initial meetings with stakeholder

groups, other Federal agencies, and researchers to identify issues with current assessment systems, investigate future needs, and to elicit comments on what is perceived as the government role in the collection and reporting of assessment data. We met with over 200 different stakeholders across the continuum of care as well as the Agency for Healthcare Research and Quality, the Department of Veterans Affairs, and MedPAC staff.

**BMS is Working to Identify Common Measures and Process for the Clinical Assessment of Patients**

A key to developing more consistent payment and quality assurance methodologies across different sites of post-acute care is the use of common measures and processes for the clinical assessment of patients. CMS and the Department of Health and Human Services as a whole are committed to the development of standardized health information terminology (e.g. Systematized Nomenclature of Medicine, Logical Observation Identifiers Names and Codes—Clinical Terms (SNOMED-CT) to reconcile disparate assessment items collected by the different health care providers in their particular settings. In addition, CMS has asked the National Quality Forum (NQF) to convene a group of technical experts to identify a standard framework for measuring functional status that could be used in CMS instruments and programs. This technical group could create a subset of items common to payment (and quality for continuity of care measures) and allow flexibility for the other items specific to a particular setting. Factors such as diagnosis, functional status, activities of daily living (ADLs), prior hospitalizations, and discharge to community are just a few elements that could serve as a common set of information collected at admission and discharge to help structure payment and quality programs. Once these changes are made, CMS could test the new instrument, and begin collecting data for use in developing more advanced methods for payment and quality assurance in post-acute care. In the short term, the potential exists to recalibrate existing SNF, IRF, LTCH, and home health payment systems based on the standardized data elements, and use the data to measure resources and establish payment levels more consistently across these sites of care.

**CMS is Collaborating with ASPE to MAP MDS to CHI Standards**

In October of 2004, CMS and ASPE contracted work to begin mapping of MDS items to the adopted medical terminologies and standards recommended by the CHI initiative. This work ensures that the future version of the MDS conforms to CHI standards thus supporting the adoption and promotion of interoperable electronic health information systems.

**CMS' Expanded Transfer Policy Helps Ensure Accurate Payments**

Due to concern that hospitals may be discharging patients as quickly as possible to post-acute settings, thus substituting post-acute care for the end of the hospital stay, CMS has proposed expanding the post-acute transfer provision to help ensure that acute care hospitals receive accurate payments for cases that those hospitals transfer to post-acute care. The provision would add additional DRGs to the existing policy that pays acute hospitals that transfer patients to a hospital or unit excluded from the IPPS, skilled nursing facility, or home health agency after a shorter than average length of stay on a per-diem basis, rather than the full DRG payment. More specifically, each transferring hospital is paid a per diem rate for each day of the stay, up to the full DRG payment that would have been made if the patient had been discharged without being transferred.

**DMS is working to Ensure that People with Medicare are Treated in the Most Appropriate Setting**

CMS covers rehabilitation and post-acute care in a variety of settings. CMS is committed to ensuring that beneficiaries have access to high quality rehabilitation services in these settings at an appropriate cost to taxpayers. Generally inpatient rehabilitation facility payments are much more generous than those paid to acute care hospitals; therefore it is important to ensure that the majority of patients treated by inpatient rehabilitation facilities truly require the higher level of care available at such a facility.

In February of 2005 CMS in collaboration with the National Institutes of Health, Center for Medical Rehabilitation sponsored a panel meeting to review available research on the types of patients appropriate for inpatient rehabilitation care and provide insight into where additional research may be needed.

**Significant Variations across Post-Acute Care Settings Exist**

It could be that the current variation in payments across settings creates incentives that inappropriately affect where providers send their patients. We should in-

investigate a more coordinated approach to payment and delivery of post-acute care services that focuses on the overall post-acute care episode or attempts to pay more consistently across different sites of care. Payments for particular post-acute care services should be more consistent regardless of the setting in which the services are furnished. An approach that relies on a single comprehensive assessment of a patient's needs and clinical characteristics could ensure that payments are at levels consistent with high quality, cost effective care regardless of setting.

The following case example illustrates how the payments under Medicare for levels of rehabilitative care received in the various settings may differ for a patient that has a primary diagnosis of a lower extremity joint replacement, which is a common patient condition.

A 74-year-old woman has experienced a right total knee arthroplasty (TKA), with a wound infection, fever, and high white blood cell count, noted on her second post-operative day. A work-up indicates the existence of staphylococcus aureus septicemia. The patient lacks full extension and has only 65 degrees of flexion on her third post-operative day. The chart below demonstrates how the different post-acute care settings provide different classifications, lengths of stay, and payments.

Setting	Classification	Length of Stay	Payment (2003 rates)
IRF	Case-mix group 804 (lower extremity joint replacement with some functional capabilities)	14 days	\$10,828.60 The existence of staphylococcus aureus septicemia, a comorbid condition (ICD—9—CM code 038.11), would place this patient into the tier 2 payment category..
SNF	Either the very high (RVB) or ultra high (RUB) rehabilitation group	14 days	\$4,446.82 for RVB and 14 days, \$6,352.60 for RUB and 14 days
LTCH	Patient group 238	14 days	\$17,671.22 for 14 days or
Home Health	High/High/Moderate group	60-day episode*	\$5,165.26 for services delivered for a 60-day episode

\*Payment is always based on 60-day episode unless low utilization or other adjustment applies.

In addition to the above-mentioned options, the patient could also receive outpatient therapy or remain in the original surgical acute care hospital, both of which would have different classifications, lengths of treatment, and payments than those mentioned in the chart. This illustrative example shows the extent to which assessment and payment across care settings varies substantially when a patient presents with the same condition in each setting.

### Benefits of Standardizing Payment Systems

An integrated payment system for all post-acute care services could encourage a focus on actual patient need and eliminate the financial incentive for providers to transfer patients from one post-acute care setting to another based on financial considerations. We also believe an integrated post-acute care strategy could help to address the growth in post-acute care spending. We realize that any site-neutral, beneficiary-centered system of paying for post-acute care services will need to allow for certain variations in costs, such as room and board among different types of providers. However, by providing more consistent payments for the same treatment in different sites, the payment structure should not influence clinical decisions about the appropriate site of care.

As mentioned above, MedPAC has recently commented on the challenges we face in coordinating our post-acute care payment methods and suggested that it may be appropriate to explore additional options for reimbursing post-acute care services. We agree that CMS, in conjunction with MedPAC and other stakeholders, should consider a full range of options in analyzing our post-acute care payment methods. In fact, we have recently issued proposed regulations for SNFs and IRFs in which we discuss the long range possibilities for an integrated post-acute payment structure. While we have not made any formal proposals, we have solicited comment on potential models from the industry and other stakeholders. This is an action step that we have taken to advance the issue and initiate a dialogue with our stake-

holders. In addition, we want to encourage incremental changes that will help us build toward longer-term objectives. An obvious problem in establishing an integrated post-acute PPS is that the research, like the payment systems, has been specific to each type of provider. Much work remains to be done to develop a case mix adjusted payment system that spans the various provider types.

In addition, ASPÉ is funding a study examining the relative cost-effectiveness of post-acute care services provided to Medicare beneficiaries who have suffered a stroke. This work as well as work that has been funded by National Institute on Disability & Rehabilitation Research (NIDRR) in the Department of Education and the private sector will provide policy makers with needed information to develop a more patient-focused payment policy.

CMS has existing models of seamless care that may serve as good examples for post-acute care payment and assessment systems. For example, through Medicare Advantage (MA), CMS makes up-front capitated payments to MA plans to provide coordinated beneficiary-focused care. The plans then determine the best care setting for the person with Medicare based on his or her health care needs. As we begin to make incremental changes toward increased standardization and a more seamless system of post-acute care and as we review public comments, CMS will consider conducting new demonstrations to evaluate the effectiveness of different approaches.

#### **Benefits of a Standard Patient Assessment Tool**

As CMS considers modifications to standardize payments in post-acute care settings, it is essential to recognize the relationship between payment structure and clinical data collected through patient assessment instruments. By examining the provider-focused prospective payment methodologies and considering patient-focused payment approaches while developing an integrated assessment tool, CMS is taking a necessary first step toward increased system integration.

#### **Increased Standardization Improves Continuity and Quality of Care**

The various assessment instruments used by Medicare providers differ because even if providers are collecting similar information each instrument collects and stores the patient's health and functional status information in different data formats, which are often not compatible (as demonstrated in the chart discussed earlier). Because of this variation, care may be disrupted when a Medicare patient moves across settings.

Increased interoperability of data standards would allow providers to share existing patient information across settings without the unnecessary burden of data re-entry for Medicare patients already receiving care in other care settings. It also may reduce the incidence of potentially avoidable re-hospitalizations and other negative effects on quality of care that could occur when patients are transferred between different facility types.

#### **Conclusion**

CMS has committed to a variety of activities to develop more consistent payment and assessment systems because we realize the benefit 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. Standardized payment and patient assessment data elements would make it possible to evaluate health and functional status across the range of post-acute care settings and bring us closer to establishing a single post-acute care payment system, with uniform payments for clinically similar admissions and a consistent set of incentives. Greater integration and coordination in Medicare's post-acute care payment system could enhance our focus on patient need while at the same time reducing unnecessary transfers between settings. Ultimately, an integrated patient-focused model could allow us to gain control of the rapid growth in post-acute care.

Thank you, Madam Chairman, for the opportunity to speak to you today about the potential for increased payment and patient assessment standardization in the Medicare program. I would be happy to answer any questions you may have.

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Chairman JOHNSON. I thank the panel for their comments. It does seem a simple thing to create a single assessment tool, but as you read through the testimony it clearly is not going to be an easy thing to do. There are also some things happening that raised a lot of questions about what we are currently doing, and I would like to share with you a sentence or two from the testimony of Carol

Raphael of the Home Health Services of New York, New York. She says, "In addition, the report shows that from 1996 to 2001, post-hospital discharge home health care utilization fell from 108,000-plus episodes to 59,000-plus episodes, yet SNF utilization increased from 52,000 to 67,000 episodes." Now, I don't know to what extent—this raises in my mind the question of whether, when we went to an episode payment, PPS under home health, whether or not we didn't incentivize the institutionalization in nursing homes of certain patients, that in some states were in home health on a very long-term basis, and by cutting off the home health option for long-term care, we actually ended up putting them in a more expensive setting and a setting less harmonious with their personal health and other needs. So, I would be interested in your commenting on that, because if our payment system is already driving certain adjustments, then we need to be aware of that, as we begin to look at how we make sure that this is a more patient-centered system and not a facility-centered system or a payment-structured system. Anyone? Mr. Hackbarth.

Mr. HACKBARTH. We have spent some time looking at those issues and, of course, a lot of time discussing them with Carol, a Member of MedPAC. Our analysis suggests that the decline in home health users was greatest among patients with the lowest expected use of home health services, number one, and greatest in those States that had the highest levels of home health utilization to begin with. We also looked at the question of whether there was a relationship between the decline in home health, on the one hand, and the increased utilization of SNFs on the other hand, and we looked at that by State. There was not a clear relationship at a State level, at least between those two things. So, we didn't see home health go down dramatically and SNF jump way, way up in the same States. So, the pattern is—if there is a relationship, it is a more complicated one than that.

Chairman JOHNSON. Thank you. Anyone else care to comment on that?

Mr. KUHN. I would just make an observation that I couldn't agree more with your assessment, the fact that we can look at the episode of care of the patient rather than the specific site of service, is something we all aspire to, and I think your comments are right on point. Also with the different silos, the providers act individually and not in concert with one another to consider the seamless transition of the patient through their entire episode of care. So, some of the fractures that you are talking about right now are evident in the system, and there is no question that we need to look at those opportunities where we can do better.

Dr. KANOF. They are not just in home health or SNF. There is evidence, such as, if you look at SNF versus the IRF, you are seeing the same type in shift in utilization depending upon what is in the community. So, you could have certain patients in community X being admitted to an IRF, but in another community, where there might be more SNFs, they are going there.

Mr. HACKBARTH. Could I just add one other point, Chairman Johnson? In evaluating the decline in home health, which was quite dramatic, we also need to take into account that the rules changed. There were some statutory changes in refining the defini-

tion of eligibility for the benefit. In addition to that, there was a major effort in HHS to make sure that the benefit was only going to patients who properly qualified for it. So, there were some factors outside the system that we think were major contributors and probably appropriate contributors to the significant decline in home health users.

Chairman JOHNSON. In Dr. Votto's testimony later on, he points to the Quality Improvement Organizations (QIO) and their work in looking at appropriateness of discharges, at least in the LTCH area, but also mentions hospital discharge planners. Have you looked at the effectiveness of discharge planners in terms of selecting the appropriate patient placement and how effective is that mechanism? Who else is doing it? How else are they getting into the system? Is there always somebody in charge of planning? To what extent is planning influenced by factors like the availability of someone at home to—if they are discharged to home—to help? In other words, how effective are the systems that we have there that we can call on? How much of the problem—because, actually, in the fine print, of your testimony, Mr. Hackbarth, you say there has been a 50-percent increase in spending since 2000 and 80-percent increase in spending for LTCHs. Now, those are just extraordinary amounts in terms of the size of the increase. When you think of the developments—not developments in medicine—but in terms of rehabilitation of stroke victims and cardiac victims and so on; how much of that is medically driven; how much of that is driven by the change in family structure, where most family members are working, so there isn't anyone home, so you don't have a choice of home care? How much is influenced by the availability of care providers? In Connecticut we are very strong on home care providers because we have had a cap on nursing home beds for several decades. So, has there been any attempt to analyze what is driving this? What are levers and why haven't we used the ones in the system more effectively?

Mr. HACKBARTH. We fear that the current system does not work well. Two reasons that it doesn't work well are, number one, there are not clear criteria on how patients should be assigned to different types of facilities. Number two, the incentives are often not right; for example, for the hospital discharge planner. So, without clear criteria and incentives pointing in the proper direction, the potential is great for patients to go to facilities that are not appropriate. Sometimes that may be a facility that is way more intensive, more costly than they need. There is also a risk in the other direction as well, that a patient could be discharged from an acute care hospital and sent to an SNF that doesn't have the capabilities that are necessary to care for that patient. So, there is a lot of work to be done to get it right.

Chairman JOHNSON. Mr. Lewis.

Mr. LEWIS. Thank you very much, Madam Chair. Let me thank each panel Member for your testimony. Mr. Director, MedPAC recommends that CMS continue to use clinical criteria to determine the most appropriate setting for patients, where the common patient assessment tool has been developed. Do clinical criteria exist for all post acute setting to determine the best placement for pa-

tient? If so, can you please provide us with some examples of the clinical criteria for each setting?

Mr. KUHN. I don't have the exact information here in terms of the clinical information for each setting. We would be happy to get that information to you, Mr. Lewis. At least with the different settings that are out there, the MDS is what is used primarily in SNFs, and it really tries to look at the highest function of the patient or the resident. The Outcome and Assessment Information Set (OASIS) is used right now for home health agencies, and that looks at a different level of functionality. So, you have two different assessment instruments looking at two different things for patients, one staying at the home, one in SNFs. Another instrument called the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), is what is used in IRFs, and is a different assessment instrument. Then, as we heard in opening comments, I think Madam Chairman stated that, in LTCHs, we do not have a patient assessment instrument.

Mr. LEWIS. Do you plan to develop plans? Or, if so, when?

Mr. KUHN. Yes. That is the key here, and the real linchpin of this whole discussion is that you need a standard patient assessment instrument that can look at those common dimensions that we need to be looking at for patients, whether it is co-morbidities, functional status, diagnosis, and so forth, so we can pull that information together and have it in a rather seamless system. We have begun to work on electronic data interchange where we can begin sharing that information. We need to now start looking at those other elements. We hope to be in a position that we can be testing products early next year. It is something that is long overdue and that we are working on at the agency right now.

Mr. LEWIS. Your agency has been looking to issues related to post-acute care since the early nineties. Can you please tell us what you have learned over the past 15 years and what changes the agency has made to address the issues that have been identified over the years?

Mr. KUHN. The big changes that have been made in the nineties and particularly in the late nineties for which Mr. Hackbarth provides some pretty good information in his testimony, included some really rapid growth in these areas. Within the Balanced Budget Act 1997 (P.L. 105-33), Congress gave CMS the authority to begin moving to PPSs in these areas. The agency has now completed transitioning to the PPS, and we think that has really begun to put the brakes on this area in terms of spending, trying to get better utilization, and trying to get better classification of facilities, to make sure we get the patients to the right place, but obviously we need to do more. I think we are at a mature place now in terms of our PPS, because we finished transitioning the last one at the beginning of this year and that was the inpatient psychiatric facility PPS. Now, while that is not a post-acute care setting, we have now finished implementing all the PPSs. So, I think it is an appropriate and timely hearing to begin thinking about the next steps to move forward. All of us need to focus on post-acute care right now.

Mr. LEWIS. Thank you very much. Doctor, thank you for being here. The CMS has provided a three-year transition period to

phase in the 75 percent threshold. Based on your study, based on your finding, RFs, do you think a transition period is justified?

Dr. KANOF. Well, what you want to make sure is that CMS (Medicare) is paying for the appropriate patient, and you want to make sure that the payments are medically necessary. What our data showed for looking at fiscal year 2003, was that in fact if we were to use the transition rules, about 60 percent of the patients had a condition that was on the list and also had a co-morbidity, so that in fact it would have matched the rules as played through in their transition. If, however, we did not include the co-morbidities, then payment would have been much lower, and less than 40 percent of the facilities would have been able to be receiving payment as Medicare IRFs. So, there is value in having this transition as—as we have said both in our report and today, that we believe CMS needs to do some refinement and clarify what are the appropriate subgroups and go beyond just using diagnose for admissions.

Mr. LEWIS. Chairman, how about do you have anything to add?

Mr. HACKBARTH. MedPAC supports the concept of the 75 percent rule. The purpose is to assure that only appropriate patients receive this intense and relatively high-cost form of care. We have urged CMS to establish the criteria and the proper diagnostic groups with a transparent process involving clinicians that have experience in the field and also clinicians that have experience with other types of post acute facilities. We have suggested that it might be appropriate for there to be a brief halt in the transition to allow that sort of public process. We would also concur that it may well be true, as GAO points out, that just a diagnosis level statement is not precise enough and that there ought to be a more detailed set of criteria to really make sure that the right patients get there.

Mr. LEWIS. Thank you very much. My time is up. Madam Chair, thank you for being so patient.

Chairman JOHNSON. Thank you. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair. I would like to pursue this questioning Mr. Lewis started on the IRFs. Dr. Kanof, Chairwoman Johnson and I wrote a letter several years ago asking GAO to do a report on this subject; and indeed you did—GAO did a report. Since then, I think the Chairman and I have heard from some who have complained about the report, as you might expect. One of the specific complaints, and I would like for you to address it if you can, was that in the course of the study, GAO only spent 1 day with the IOM and interviewed just 14 clinicians, the implication being you just didn't do your homework. Is that true? If so, how do you justify that?

Dr. KANOF. Well, in fact, we too have heard some similar questions, so I can answer that one. I know that specifically, as you go through the methodology and the report, yes, we did speak to many clinicians. We convened experts at, but we spoke with many experts in the field and we spoke with IRFs and we spoke with fiscal intermediaries, and we spoke with a total of 106 individuals, and 65 of them—so over half of them—are clinicians. So, we really do believe that we have a wide breadth of individuals that we spoke with.

Mr. MCCRERY. Do you think that you should conduct any additional clinical research to further assess the needs?

Dr. KANOF. One of our recommendations in the report is that, in fact we do believe that there is a need for more clinical research. The CMS are working with the National Institute of Health (NIH) to clearly convene more individuals, not as much because the evidence really is not there to say that there should be more conditions and the evidence isn't there to show that you have different outcomes if you are in an IRF or a SNF, but actually more to begin to think about what is the research and how to find out the important question as to who should be admitted to an IRF.

Mr. MCCRERY. Thank you for that explanation. Continuing on this, you use the percentages that the GAO concluded regarding how many IRFs could comply based on 2003 data. One piece of data that we have been provided with is that only 6 percent of IRFs could meet the 75 percent criteria in 2003. Does that comport with your—

Dr. KANOF. That is true. That was if you—Mr. Lewis was asking me—I believe he was asking me how many would work, comply if we were using the transition.

Mr. MCCRERY. Phase-in.

Dr. KANOF. Right. So, in the phase-in it is about 60 percent. If there is no phase-in and you just go to the 13 conditions, it is 6 percent.

Mr. MCCRERY. Well, that would lead us to the conclusion, wouldn't it, that when it is fully phased in, only 6 percent would be able to comply.

Dr. KANOF. No, because you would have to assume that there is no change in anybody's behavior between the phase-in and 2007. I am not disagreeing with you that it would probably be a relatively lower number, potentially, than 75 percent, but in fact the way that the phase-in is, is that there are these 3 years of the additional co-morbidities. In fact, many of the IRF medical directors that we spoke with did acknowledge that if they were to be paying closer attention to the diagnoses that they were being admitted, they would be paying closer attention to—in fact looking at the diagnoses that they were being admitted for. In 2003 you have an environment where CMS is not really -has not looked at the 75 percent rule. As Mr. Hackbarth explained, there is really no incentive for anybody to be thinking twice about where somebody should be admitted. That is why I am not sure that the 6 percent is correct.

Mr. MCCRERY. Well, in any event, I think one thing that we need to consider is the financial viability of these rehab centers if they have to make the changes necessary to come under compliance under the 75 percent rule. That is the big question. Do they go away if they have to comply, or are constraints so severe that they can't get enough patients under those conditions to sustain themselves financially? Given that—just one last question on this, Madam Chair—do any of you think that the rule should be reexamined with an eye toward more leniency for more than 3 years as we get more data? Or do you think the three-year phase-in is exactly the right path that we should be on?

Dr. KANOF. I think one of the important points, though, that I said in my oral statement, too, is that—and I understand the ques-

tion you are asking—is, though a significant amount of the patients from the 2003 data that were being admitted to IRFs are single joint replacements of knee and hip, there is evidence that those are individuals that do not need to be admitted to IRFs. So, I think that in addition to the question in terms of the transition, I think clearly also that what we need to consider is are we spending appropriate dollars for individuals in these settings.

Mr. MCCRERY. I don't question that. You didn't really answer my question.

Dr. KANOF. I think that the transition as proposed gives—CMS gives IRFs the ability to process patients, learn to do assessments, allows CMS the ability to develop finer refinement of the rule. So, the answer, as I said to Mr. Lewis, would be yes.

Mr. MCCRERY. Mr. Kuhn, would you agree?

Mr. KUHN. It is a little bit premature to judge whether additional leniency needs to be built into the system. We did build additional leniency in the system when we published the rules last year, when we moved from ten conditions to thirteen conditions. I think, as Dr. Kanof said, there are going to be behavioral changes by these facilities. I think we need to see more data, see how they are transitioning, seeing how they are working as they move forward. The key here, as she said, is that we don't want Medicare to be at risk of overpayments for these services, because I think that clinical evidence in the area of orthopedic joint replacement, as she indicated, is rather weak concerning whether individuals should be in these facilities.

Anecdotally, I recently saw a news article about a particular facility that decided to convert itself from a rehabilitation facility to a sub-acute care facility, an SNF. Most of the employees were able to transfer over to the new facility, but I think it is pretty clear that the patients are still getting the same level of services they need but in the right setting. The behaviors and payment systems, are driving us to change here rather gradually. I think more data is needed. We need to all monitor it closely, because I think your concern is genuine that these patients should get the care that they need and we want to continue to work with all the stakeholders to make sure that that happens.

Mr. MCCRERY. Thank you very much. Thank you, Madam Chairman.

Chairman JOHNSON. Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chair. Thanks to the panel Members for being here. Mr. Kuhn, MedPAC says, and I think I am quoting you correctly, that the system doesn't work well. We just heard that in the testimony. Your agency has been looking into issues related to post-acute care for the past 15 years or so. Can you give us an idea of what you may have learned and what recommendations your agency has made to improve matters?

Mr. KUHN. That is a good question. I think we have got our arms around a couple of things. First I think we have really been able to slow some of the growth in some of the areas of spending that has been out there, and I think that has been effective, although we still see growth in this area. We have also learned that there is the need for additional research in a lot of these areas, particularly for LTCHs, and also for IRFs and others. Importantly,

what we have really seen is that, now that we have finished the work with all the PPSs, it is time to move the whole system forward and think about a site-neutral payment, one that focuses on the patient instead of the name on the door of the facility. Currently, if it is one kind of facility, you pay one rate and you pay another facility another kind of rate, but the money really needs to focus on the patient for the entire course of care. That is one of the big lessons here, and all of us need to be thinking about this in the future.

Mr. THOMPSON. Thank you. Mr. Hackbarth—and I didn't ask them to say that—but the site-neutral payment issue is something that has interested me a lot. When we talk about care versus the site, how much of the site part of it is determined by regulatory changes or even State law in some instances? It seems to me we have the same patients, we are just moving them around to follow the money, and not in a negative sense. Everybody that is providing health care today is struggling to do so, and they are trying to figure out what works best for them and how they can maximize their reimbursements to continue to provide quality health care. If in fact that is what we are doing, it seems to be in conflict with what you had said earlier about the high quality and appropriateness of care at a reasonable cost.

Mr. HACKBARTH. Well, let me go back to your first question: How much of a difference in cost is attributable to a difference in regulatory requirements and the like? I can't give you an answer to that. Surely some of it is.

Mr. THOMPSON. Not so much the cost, but the care versus the site; where you are taking care of the same people, just you are doing it in a different location—

Mr. HACKBARTH. The issue oftentimes is whether a given patient needs that particular type of care that may be more intensive and, therefore, more costly. You can have—we did an analysis of care of patients with knee and hip replacements, that some of them go home and receive home health care or outpatient therapy, some of them go to IRFs, and some go to SNFs. Well, in fact although they all have the knee replacement in common, they are very different in other respects, in terms of things like care givers at home to support them, in terms of their clinical characteristics. So, a diagnosis alone, a common diagnosis doesn't tell you all you need to know about the differences in patients. So, if we have a patient that could go home—and orthopedic surgeons tell us that most patients, Medicare patients with a single knee replacement can go home. If they end up in an IRF, they may not get poor-quality care, but they may get much more expensive care than they need. That is our concern.

Mr. THOMPSON. Thank you. A question—and I guess, Dr. Kanof, I don't want you to feel left out, so I will ask you. How do we balance that need for data vis-a-vis the need for health care, and, at the same time, try and consider the morale of the health care providers? I can't tell you how many times I have heard from providers that they feel like they are data collection employees, and they are spending most of the time at their home health visit collecting data. I am sure some of it has got to be valuable, but how

do you balance that need to make sure it doesn't conflict with the health care part of it?

Dr. KANOF. Well, I think that one of the common things we have all said is that one way to balance this all is in fact to try to create more of a uniform assessment tool that we could then use regardless of what setting you were in, so that from a health care provider they don't need to sit there and say, okay, this is my home health patient and this is my Durable Medical Equipment (DME) patient and this is my SNF patient, but that in fact there is one tool that might have certain questions on it that you might ask or not ask, depending upon the setting, but that there is more of a uniform way of asking the question. One of the interesting distinctions between all the current tools is that they all have, in fact, different grading scales, so on one you have to remember that the lowest number is the high and the high is the low. So, I don't think from a health care prospective or a health care provider prospective you can eliminate the work involved with the tool, but there are many ways that we could develop tools that are more user friendly, client specific, patient specific, and would still give us the information for both payment and quality. I don't want to forget quality.

Mr. THOMPSON. Please hurry. Thanks.

Chairman JOHNSON. Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chairman. Listening to the discussion about home health a little bit ago, while I wasn't honored to serve on this Subcommittee, I remember the discussions about the Balanced Budget Act 1997 as a freshman Member on the full Committee. I remember, Mr. Hackbarth, you touched on this, that there were some substantive changes that we made. We saw the rapid growth in home health, and we saw—let me characterize—some particular States where the growth was really going. So, we painted with a very broad brush to try to rein those in, and, as a result of that, though, there were many efficient good home health agencies that folded their tents in the aftermath of that as well. Just a parenthetical comment.

I do want to ask you, though, Mr. Hackbarth, because as we look now at the rapid growth in long-term care, I think—and my characterization of what you said was, number one, no clear criteria, and number two, the incentives are skewed, in my characterization. Is that a conjunctive or disjunctive? In other words, if there were clearer criteria, would the incentives be okay? Or is it clear incentives and the incentive—excuse me, clear criteria and, by the way, the incentives don't really fit?

Mr. HACKBARTH. That is a good question. MedPAC's initial recommendation on LTCHs was to develop the criteria. So, if you can't change the incentives, at least have criteria on who it is that needs this expensive type of care. We thought that there ought to be both patient criteria and facility criteria. This is what it means. These are the services that LTCHs should be delivering. So, we thought that is the easiest first step. As I said in my opening statement, that doesn't deal with the incentive issue. If we really want the decisions made properly, we need to address that as well. There are a couple different paths that you might take. One is to bundle all the post-acute care payments in a lump, and then give somebody responsibility for managing that and holding them account-

able for both quality and cost performance. Another approach would be to establish a case manager that doesn't bear the utilization risk, but they are an impartial party evaluated under quality performance in getting patients to the right settings. So the first step is criteria. We don't think you can stop there. In the longer run we have got to do something about the incentive issue as well.

Mr. HULSHOF. I appreciate that. Mr. Kuhn, we sought some information from my home State of Missouri, tried to get some data, and so we turned to the Missouri IRFs. What they did was to take the last six months and then extrapolate to a full year to come up with an annual estimate. What they told us was that 17,000 patients would be treated over a one-year period. As all of us have expressed, as the 75 percent rule is being phased in, there is a lot of concern about how that is going to impact the 17,000-plus folks that are receiving this care.

I have got the—Mr. McCrery referenced the April 2005 GAO report, and we have batted that around a little bit. The report's suggestion—and Dr. Kanof echoed that in her testimony today—that a patient's medical condition or diagnosis in isolation is not, in my view, a fully sufficient measure by which to classify IRFs. In fact, let me—I almost applauded what you said a moment ago when you said let us focus on the patient, the patient's functional status, functional decline, motor and cognitive function, functional disability. These things in a best-case scenario would be taken into account. Let me just even—a quick personal note. Two years ago my mother-in-law, 57 years of age, an active Licensed Practical Nurse, one night, brain aneurysm. So, our families experienced in a very real way—and I would even say that not just the initial diagnosis after this aneurysm, but even to see the functional changes over the last two years in this case. So, what is CMS—give us some wisdom as far as CMS trying to incorporate some of these functional measurements into the rule.

Mr. KUHN. I'd like to provide a couple of quick observations. First, concerning the data, we have been looking at some data elsewhere that others have been bringing forward to us. Remember in 2002 we suspended the enforcement—a moratorium on the 75 percent rule. Between then and July of 2004, when we implemented the two-year moratorium of the new rule, and there was no enforcement of the rule, we saw utilization spike. So, for those that are saying that we are seeing this rapid reduction in terms of the number of people being served in IRFs, during the moratorium there was a spike in admissions. If you go back to maybe a baseline in 2002, you might come out with a different number. This is just a cautionary note on the interpretation of those data.

Second, when we talk about the folks that aren't being served in rehabilitation facilities now, when you ask the industry where they are going, it appears that they are getting services elsewhere, for example, in an SNF or through home health services. They are not going without services. I think that is an important issue. To address the key point that you raised in terms of what we are going to do next, we have this classification system with 13 categories that we are using with IRFs. We are looking at research in this area. We convened a panel with the National Institutes of Health in February of this year; we will receive a recommendation from

them about next steps so we can begin to look at functionality with some of these issues. We think further research is an important next step, and that is how the Agency plans to proceed. We have the effort to enforce the classification system, but we are not stopping there. The research will continue, because we will continue to look in more detail at this area. As Dr. Kanof said, there is not a lot of research in this area, so we all need to step up to the plate to help support that and make that happen.

Mr. HULSHOF. Thank you.

Chairman JOHNSON. Thanks. I am going to ask a couple of summary questions because we have this vote and then we have ten or eleven five-minute votes. So, I am sorry to inconvenience the next panel, but I think we will start you all at once after this series of votes. Actually, if there is anyone who can't stay, because that is an hour's delay, would you—would one of the staff members go back? Kathleen will come back and let you know; maybe we can get in one or two before we leave. I think in kind of wrapping up—and we have all acknowledged that there are big problems in the system, that our payment system doesn't assure that patients get to the setting in which they get the care they need, for the least amount of public dollars. Five years ago we did ask CMS to do a report on this, and it was due in January. Now, recognizing that CMS has had a lot of other responsibilities as well, nonetheless you have all been concerned about it, and we have got bits and pieces. Why aren't we closer to a single assessment tool and to a structure that uses that tool to at least direct the first level of flows, and then to pick up at the institutional level the more precise detail that we need for payment?

Mr. KUHN. I would just make this observation, Madam Chairman, that sometimes progress is measured in inches rather than feet. We are making progress in this area, perhaps not as rapid as some would like to see, but we are making progress in terms of things that we are doing. In terms of the report, you are absolutely right. We owe the Congress a report and we did not meet the deadline that we had out there. We are doing well on the report. It is a much more complicated issue than we had originally thought. I wish I could give you a certain time when we could have it deliverable to you; I can commit to you that I will have CMS staff follow up with Committee staff on a regular basis to give updates, and as we get information we will make that available to you as well, because this is an important topic, and the sooner we can give information to you all so you can have good data from which to make decisions, we would like to do that for you. So, we will continue to work to get that to you as soon as possible.

Chairman JOHNSON. Thank you. I appreciate that. I hope that you will continue to work as you have with the LTCH on the material that they are developing, which is probably more specific patient-based material than I think anything I am aware of the Federal Government doing. So, I think that would be useful.

Mr. KUHN. One quick thing about LTCHs. Just to let you know, as part of the effort we are doing the research. Actually, in the next week or two we will be in the field with that research, visiting the facilities. We hope to have a report by the fall, and we hope to be

able to include that in next year's regulation cycle. So, we are making progress there as well.

Chairman JOHNSON. I wonder how you view your 25 percent rule for the LTAC in the context of this discussion about patient-centered health needs.

Mr. KUHN. When we looked at the LTHC issue, we saw a real incentive to unbundle services in these facilities when they were co-located in the same facility. To a degree, we were seeing two payments for the same episode of care, and that concerned us a great deal. So, we tried to phase into this new system at the 25 percent level. We made a number of exceptions to consider whether they triggered outlier payments, whether they were in rural facilities and whether they were the dominant hospital in a marketplace, and we tried to create as many opportunities there as well. Importantly, we said we needed to move pretty aggressively on research dealing with patient-specific criteria, things that MedPAC had brought forward. Again, we hope to have that report in the fall and move that into the immediate regulation cycle. So, I think we will hit our milestones on this one and keep the process moving forward.

Chairman JOHNSON. I hope when we get to that point we can eliminate the 25 percent rule, because it is absolutely arbitrary and there are examples of pairing long-term care institutions with institutions that do a lot of heart surgery or other kinds of procedures that clearly will result in a referral to an LTAC and to require that we pay the \$850 ambulance fee to ship them someplace else, so that the other hospital can pay \$850 to ship someone else into that LTAC bed a few miles down the road. You get into that kind of bizarre dance because you are looking at the source from which the referral came rather than the patient's need. If the patient is qualified and is going to get that care here or ten miles down the road, we should not be insisting that they be shipped ten miles down the road. So, the arbitrary impact of the current 25 percent rule is, in my mind, anti-patient-centered health care, but also just one more thing that pumps our costs up without any benefit to the patient.

So, I hope that we will be able to move to a criteria-based system and get rid of some of these kind of arbitrary policies that we put in place during the years when we had inadequate criteria. Thank you very much for your testimony. I look forward to your input as we move down this road. We must move down it, and we cannot actually move down it as slowly as some of the testimony sort of implies that we have in the past and we will in the future. The future cannot repeat the past in regard to the criteria-based system that we need to develop for post-acute care. Thank you very much for being here. The Committee will reconvene five minutes after the last vote. So, for those of you on the next panel it will be at least an hour. Thank you. My apologies.

[Recess.]

Chairman JOHNSON. The hearing will reconvene. Other Members are on their way, but in deference to the witnesses who have been waiting such a long time, my apologies again, on the record, for having had to take such a long break for the votes. We are reconvening now, and we would like to start first with Ms. Ousley.

**STATEMENT OF MARY OUSLEY, EXECUTIVE VICE PRESIDENT,  
SUNBRIDGE HEALTHCARE, ALBUQUERQUE, NEW MEXICO,  
ON BEHALF OF AMERICAN HEALTH CARE ASSOCIATION**

Ms. OUSLEY. Good afternoon, Madam Chairman and Members of the Subcommittee. I appreciate the opportunity to be here today to provide a perspective and recommendations on how to improve the efficiency, quality and reimbursement uniformity of post-acute care. I am the immediate past Chair of the American Health Care Association, representing over 11,000 Members and the 1.5 million individuals that we serve each day and the two million care givers that provide that care. I would like to thank the Chair for her leadership on this issue and her commitment to ensuring America's seniors receive the highest quality care. Like many of the policy debates regarding the financing of our Nation's health care system, the problem we are discussing today relates to the fragmented and sometimes irrational nature of our health care services payment structure. In post-acute care, it seems that we really have it backward. Our post acute payment structure is tied to where the patients receive care, not the actual services that they require. As highlighted and talked about earlier, in the June 2004 report to Congress, MedPAC examined all of these significant differentials and distinctions in care across the post acute continuum. Not only does CMS require different patient assessment instruments for three of the four post acute providers, the law also requires each provider type to be certified under different criteria. The CMS ensures patient safety and quality in each setting through different regulatory structures.

Obviously, the physical settings where patients receive care are very different, from the home to the nursing facility to the hospital. Post-acute providers, physicians and others, involved in patient care believe in hierarchy of acuity among the different settings and assume that patients with the highest clinical needs will actually receive care in the highest acuity setting. Research and experience show that different post acute settings actually serve very similar patients. An overlap in patient population can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research. However, that overlap is many times inappropriate. For certain DRGs, IRF payments can be up to three times more than skilled care, and for LTCHs, as much as ten times more than skilled care. Some of this is clearly due to variations in severity of illness of our patients, but because there is no common patient assessment tool or outcome measures across all settings, it is absolutely impossible to ascertain whether patients are being treated in the most appropriate setting and whether resources are being allocated efficiently and appropriately.

We believe that it is 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 this comprehensive assessment tool. Until CMS can finalize and apply a uniform system, we do believe we can do a better job today in placing post acute patients. We support, and the American Health Care Association supports, the continued use of the QIOs to review the appropriateness of placement for patients with hospital stays, CMS should continue to apply hospital discharge planning that is re-

quired today by law and regulation, and it should do so as a starting point to standardize post acute assessment tools. We also believe it is very important to implement the 75 percent rule to ensure IRFs are treating appropriately placed patients.

Madam Chair, you have heard from us on many occasions and you have heard actually from me on several different occasions regarding the importance of sustaining our quality initiatives. HHS has noted in several recent reports they are working. The quality of care and services in our Nation's nursing homes is improving. Nursing facilities currently publicly disclose the information to patients and their families on quality indicators. All providers should disclose comparable information. This will include increased patient knowledge and improve the quality of care and services delivered. Also, we believe that any system we construct should allow for flexibility so that clinical judgment can be used effectively. A beneficiary's clinical profile may indicate a need for home health, but home health may not be available or they may not have the capacity to take a new patient. Therefore, the system must be flexible to allow for facility or market limitations.

In the final analysis, there are many potential changes that would better align financial incentives with clinical placement. Tightening and enforcing the new and existing certification requirements are one, and enhancing—enhancing the role the QIOs are playing in reviewing the appropriateness of placement. Madam Chairman, at a time when the President and Congress are being forced to consider budget cuts in health care programs, the first priority must be to ensure that we are using existing resources efficiently and effectively by establishing a post-acute care structure that is patient centered, not site centered, we believe that can happen. We believe that this Congress must and should make the development of the common patient assessment tool one of its highest priorities, and we look forward to working with you and this Committee on this issue. Thank you very much.

[The prepared statement of Ms. Ousley follows:]

**Statement of Mary Ousley, R.N., Executive Vice President,  
SunBridge Healthcare, Albuquerque, New Mexico**

*On behalf of*

**The American Health Care Association (AHCA)**

Good morning Madame Chair, and members of the Subcommittee. I appreciate the opportunity to be with you here today, and to provide you with perspective and recommendations on how to improve the efficiency, quality and reimbursement uniformity of post-acute care.

My name is Mary Ousley—and I am immediate past Chair of the American Health Care Association. I speak today on behalf of all members of the American Health Care Association (AHCA). We are a national organization representing nearly 11,000 providers of long term care, providing critical long term care services to more than 1.5 million elderly and disabled people every day and employing more than 2 million caregivers.

I have been in the care giving profession for nearly three decades. I am a registered nurse and a licensed administrator. I am intimately familiar with the challenges of being on the front lines of care giving—and highly cognizant that providing quality care to our seniors, necessarily, is a collective and collaborative effort.

I have worked formally and informally with the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), in various capacities on many issues representing the long term care profession.

I'd like to thank the chair of this distinguished subcommittee for her leadership on this issue, and for her commitment to ensuring America's seniors receive the highest quality health care our great nation has to offer.

Like many of the necessary policy debates we now see on Capitol Hill regarding the financing of our nation's health care system, the problem we are discussing today relates to the excessively fragmented and irrational nature of our collective health care services payment structure.

When it comes to post-acute care, we now have it backwards: our post-acute payment structure is tied to the institutional setting in which patients are placed—not to the services required by patients.

In its June 2004 report to Congress, the Medicare Payment Advisory Commission (MedPAC) examined the significant payment differentials and distinctions in care provided across the post acute spectrum.

CMS requires different patient assessment instruments for three of the four post-acute care provider categories. The law requires that each provider type be certified under separate criteria. CMS ensures patient safety and quality in each of these settings through vastly different regulatory structures. In addition, the physical settings in which patients receive care greatly differ, ranging from a patient's home to a nursing home to a hospital.

Most post-acute care providers, physicians and others involved in patient care believe in a hierarchy of acuity among the different settings and assume that patients with the highest acuity clinical needs will receive care in the highest acuity setting. Some research as well as provider experience shows that different post-acute care settings sometimes serve similar patients. This overlap in patient populations can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research; however, the overlap is sometimes inappropriate and results in Medicare overpayment.

For certain DRGs, IRF payments can be up to three times more than SNF payments, and LTCH reimbursements can be up to ten times more. Some of this is clearly due to variations in severity of illness, but because there are no common patient assessment tools or outcomes measures across all settings, it is not possible to ascertain whether patients are being treated in the most appropriate setting, and whether resources are being allocated efficiently and appropriately.

First and foremost, it is 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 this comprehensive assessment tool.

But until CMS can finalize and apply a uniform system, it can do a better job of placing post acute patients in the most appropriate care settings. For example, AHCA supports the use of hospital discharge planning as a starting point to standardize post acute assessment tools.

For patients with prior hospital stays, CMS should continue to apply hospital discharge planning that is already required by law and regulations. AHCA also supports continued Quality Improvement Organization (QIO) review of the appropriateness of patient placement.

CMS should also implement the "75 percent rule" to ensure IRFs are treating appropriately-placed patients and not those who could be effectively treated in SNFs.

Madame Chair, you have heard from us on many occasions regarding the need to maintain and sustain our quality initiatives—which, as HHS has noted in several recent reports, are working. Nursing facilities currently disclose information to patients and their families on various quality indicators. All providers, across the board, should disclose comparable information. This will increase patients' knowledge base and improve the quality of care delivered by all providers.

As this Committee will readily agree, any system we construct should allow for flexibility, so that clinical judgment can be effectively exercised in the best interests of patients. Even though a beneficiary's clinical profile is a good match for home health care, a home health agency may not be available or may not have capacity to take a new patient. Therefore, the system must be flexible enough to allow for facility or market limitations in post-acute care supply.

In the final analysis, there are many potential changes we could make within the existing system that would better align financial incentives with clinical placement decisions. These include ideas such as tightening and enforcing new and existing certification criteria for IRFs and LTCHs, and enhancing the role of QIOs in reviewing appropriateness of patient placement.

Madame Chair, at a time when the President and Congress are being forced to consider budget cuts in many essential health care programs, the first priority must be to ensure we spend existing resources wisely and efficiently—and in a manner that best serves our seniors as well as our taxpayers.

By establishing a post-acute care structure that is patient centered, not site-centered, we can indeed do so.

Despite all of the big picture changes now being sought on the Medicaid and Social Security fronts, the development of a common patient assessment tool for post-acute care services must be a high priority in this Congress—and we look forward to working with you and this Committee to ensure this issue receives the focus and action it deserves.

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Chairman JOHNSON. Thank you very much, Ms. Ousley. Ms. Raphael.

**STATEMENT OF CAROL RAPHAEL, PRESIDENT AND CHIEF EXECUTIVE OFFICER, VISITING NURSE SERVICE OF NEW YORK, NEW YORK, NEW YORK, ON BEHALF OF THE VISITING NURSE ASSOCIATIONS OF AMERICA**

Ms. RAPHAEL. Good afternoon, Madam Chairwoman. I am pleased to be here on behalf of the Visiting Nurse Associations of America, the national association for nonprofit, community-based Visiting Nurse Agencies (VNA) across the country. I appreciate the opportunity to help the Subcommittee review the current Medicare post-acute care system and determine whether some areas, in fact, are in need of reform. As you pointed out, post-acute care is a very important part of the health care system, not only because because of what we heard, that one-third of people who leave hospitals go on to post-acute care, not only because it is likely to grow, but also because what happens in post-acute care affects what happens in the rest of the system. We know the first 60 to 90 days after someone has an acute episode are really pivotal. We know that we can do a lot to prevent re-hospitalizations and those costly transitions in and out of acute care. Basically, the VNAs have two recommendations.

Like my colleague, we believe the post-acute care system should be built around the patients, their needs, and not around facilities. Second, I think we have to move to enable Medicare to be what I would call a “value purchaser” in the future of post-acute care. We know the system is very complex, not only because of what we have heard about the difficulty of commonalities across sites, but also because of what you, Madam Chair, pointed out this morning. We bring home 1,000 people from hospitals every week, and I can tell you that often the process of decisionmaking is very compressed. A family will get a call in the morning that their family Member is being discharged that day and all of the decisions have to be made within a few hours. The pressure upon discharge plans is enormous, and many patients and families really are not educated about what their options are; and I think this is the context in which we currently operate. We do believe we need to move toward a common assessment system. I call it a “system” because it is more than a tool. We need a common assessment process, and we really need to build that on a foundation of understanding how similar are the patients who were cared for in these different sites, what are the services, and what is the mix and intensity, because we don’t really have solid evidence that will inform us as to the degree of overlap in suitability.

I can speak for home care. Thirty-1 percent of the patients that we take care of at VNAs are in rehab, but I believe that for nursing homes it is 75 percent and for rehab facilities it is probably 100 percent. Many of the people that we see do not have conditions that require the standard rehab. Many of them have congestive heart failure, complex diabetes, pulmonary disease, and so forth. So, I think we need to start with understanding the patients. Now, much of what we do in a home care setting is similar. If someone has had a stroke, we continue the treatment on anticoagulants. We do work on rehab, physical, occupational rehab, and dealing with language impairment. We do monitor patients to try to prevent someone from landing back in the hospital, but some of what we do is very different because we are focused on the care giver, supporting that wife, husband, daughter, son, and so forth. We are also focused on teaching the patient because that patient has to live with some degree of impairment for the rest of his or her life. We are focused on the underlying diseases, like hypertension, which contributed to the stroke in the first place. So, I think we really need to devote time and research to understand how these sites actually compare.

I also am a believer in involving the patient in assessment. I always say, "Quality is in the eye of the beholder," and we need to find out from the patient whether they think they have made progress and have had a good result. I do believe that a common assessment instrument has to complement what we do in our own sites. We use OASIS. It is a system that measures outcomes and has a mechanism for payments which I think is unique; we want to hold on to that. You need that instrument to do care planning, to monitor and change the care plan as the person's condition changes. We believe that the implementation of OASIS, albeit painful at times, has really caused us to focus on outcomes. We no longer provide a visit; we are really taking care of a patient to produce the best possible result. That has been an important change, and it has also enabled us to move toward public disclosure and compare outcomes in the home care field. So, I believe that we need to really not replace what we have, but find a way to supplement it.

I think that as we look to Medicare as a purchaser of post-acute care, we heard this morning that there are substantial differences in costs in these settings, and we do not know what the outcomes are for the same patients who are cared for in each of these settings. This is what we do know: We do know that people prefer to be in their own home whenever possible. We do know that the States are trying very hard, as we speak, to rebalance their systems to move from institutionalization to home- and community-based care wherever possible and wherever appropriate. So, I believe that in order for Medicare to get the best value for the dollars it spends, we should have as our guidelines to always be able to help patients make choices that will be the least restrictive, least intense and least costly. I would like to conclude by saying that I do not believe that decisions are always made, nor should they always be made, solely on clinical grounds because, legitimately, people make decisions based on proximity, capacity, confidence in an institution or an organization, availability of care givers, and cognitive status. All of those need to be knit together to create the

post-acute care system of the future. Thank you very much for the opportunity, Madam Chairman.

[The prepared statement of Ms. Raphael follows:]

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

Madam Chairwoman, Congressman Stark and Members of the Subcommittee:

Good afternoon. My name is Carol Raphael and I am the President and CEO of the Visiting Nurse Service of New York (VNSNY). VNSNY is the largest non-profit home health agency in the United States. Based on 112 years of experience in serving the diverse population of New York City, VNSNY has an in-depth understanding of the health care needs of some of the most vulnerable individuals in our country and on how to cost-effectively meet those needs. In 2004, VNSNY had an active daily census of 24,000 patients and delivered more than two million home visits.

I am pleased to be here today on behalf of the Visiting Nurse Associations of America (VNAA), which is the official national association for non-profit, community-based Visiting Nurse Agencies (VNAs) across the country. For over one hundred years, VNAs have shared several common goals: to care for the sick and the disabled, to help people recover their strength and independence, to partner with their communities in improving public health care, and to assure that all people, rich or poor, have access to the home care they need.

VNAs created the profession of home health care over a century ago, and it is our hope and intention to provide high quality home care for at least the next one hundred years. That is why we are grateful to help the subcommittee explore current Medicare policies for post-acute care and determine whether some of those policies are in need of reform. This is particularly important in light of the anticipated pressure that will be placed on the health care delivery system as the baby boom generation retires and begins to access post-acute and long-term care services on a large scale.

At the outset, the VNAA agrees with the subcommittee that post-acute care should be more patient-focused rather than facility-focused. Decisions about where individuals receive post-acute care should be determined by patient characteristics and needs. Medicare currently pays for post-acute care in four separate settings—Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Long Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs). Each payment system uses different eligibility criteria, units of payment, quality measurements and assessment instruments. We believe it is important to conduct research on patient characteristics of those served in each setting in order to better understand their common needs and understand the degree to which services overlap among the different settings.

The VNAA therefore recommends that a mechanism be developed that compares patient characteristics, patient outcomes and costs across settings. We further recommend that a uniform assessment process be developed to assess patients at the same points in time, such as at admission and every 60 days.

A post acute care assessment process should not replace OASIS (Outcome Assessment Information Set) or perhaps any other existing tool, but should have the specific purpose of identifying upfront what type of post acute care would produce the best outcomes for an individual for the least amount of money based on standard criteria and patient choice. In order to do this, VNAA believes that it is essential to begin comparing patient characteristics (in order to identify the overlap of such characteristics), outcomes and payments across post-acute care settings. Once the best setting for post-acute care is identified, an assessment instrument specific to that setting can then be used.

**Current patient assessment and payment systems**

CMS's conversion of the four different provider settings to prospective payment systems during the past six years happened sequentially rather than concurrently. Each assessment tool had its own purpose and often the original purpose for the tool was different than its primary function today. In the case of home health care, the OASIS instrument was conceived as a joint effort by CMS and the home health community to develop an outcome measurement tool rather than a tool for predicting costs and reimbursement. The goal was to select the best variables to measure the positive outcomes of home health care. It was also developed to assess an individual's ability to function in his or her own home. When the Congress mandated the creation of the home health PPS system in the Balanced Budget Act of 1997, OASIS was adapted for payment purposes because it was the best tool for pre-

dicting costs available at the time and would enable CMS to implement PPS expeditiously.

The assessment instruments that have been employed in other post-acute settings were adopted for specific purposes unique to those settings as well. Each was designed with an eye toward the unique aspects of the care model involved rather than with consideration of commonality in patient description across care settings. For example, the IRF assessment tool was shaped to evaluate only rehab outcomes. Therefore, each assessment tool carries with it unique metrics that are not necessarily compatible in other settings.

During my six year tenure as a MedPAC commissioner, I was a proponent of ascertaining the degree to which a uniform patient instrument could be developed. I thought that given MedPAC's concerns around the SNF instrument (MDS), which was originally designed for care planning for long-stay patients, and concerns about the RUGs III system, it made sense to use those concerns as an opportunity to do more standardization across post-acute care settings. However, MedPAC staff found that the definitions of care, the time periods for assessing patients, and the scales used varied to such a degree that it would be difficult to move toward consolidation.

#### **Uniqueness of Home Health Care**

A thorough understanding of the differences of the various post acute care settings will help Congress and CMS understand what is comparable across provider settings and recognize which aspects of each care model are integral to that care model and therefore not comparable. Each of the settings has unique characteristics. With respect to home health care, we cite the following salient features:

- Home health clinicians operate independently in patients' homes and treat multiple acute and chronic conditions. They must be trained to independently intervene in emergency situations, such as kidney failure or congestive heart failure. They are responsible for overseeing and implementing a patient's entire plan of care as specified by the physician and in consultation with the physician.
- Most beneficiaries express a strong preference for home care rather than institutionalization. Home health agencies have enabled millions of people to stay in the comfort of their own homes who might have otherwise been in more restrictive settings.
- Home care is cost-effective; the Administration and the National Governors Association want to "rebalance" Medicaid expenditures in favor of home and community-based care. The differences in cost in post-acute settings can be substantial. IRFs are paid on a per case rate and costs can range from about \$5,000 to \$17,000 depending on functional status and co-morbidities.

According to the 2004 Annual Statistical Supplement to the Social Security Bulletin, the average cost to Medicare for 60 days of home health care in 2004 was \$2,213. In contrast, the average cost to Medicare for 60-days of skilled nursing facility care was \$28,560. And, the average cost to Medicare for only one day in the hospital was \$3,608 in 2004.

However, recent data from MedPAC demonstrates a downward trend in the use of home health care following hospital discharge. A June 2003 MedPAC report states, "we find substantial declines in the use of home health care, increases in the use of skilled nursing facilities and other post-acute providers, and some substitution of SNFs for home health services following hospital discharges." In addition, the report shows that from 1996 to 2001, post-hospital discharge home health care utilization fell from 108,529 episodes to 59,101 episodes, yet SNF utilization increased from 52,710 to 67,647 episodes. All other post acute providers' post-hospital discharge utilization increased from 23,517 to 31,163 episodes.

#### **Development and Benefits of OASIS**

Recognizing the challenges of developing one assessment tool for all post acute care settings, it is important to note that OASIS has become a very valuable assessment tool for home care. For the first time, OASIS has given the home health industry and the government national data on publicly reported outcomes for home health care. Before OASIS, there was absolutely no national data to benchmark our clinical and operational practices in order to improve outcomes. Most importantly, OASIS is a motivator for internal quality improvement efforts and for focusing on patient outcomes because an agency can clearly see progress between the admission assessment and the discharge assessment.

Significant amounts of resources and time have been invested by home health agencies in implementing OASIS into their businesses. The complexity of the instrument creates a constant need for training and retraining staff. Now that home health agencies are beginning to see the value of the thousands of dollars that they have individually invested on average in implementing OASIS into their practices,

the idea of transitioning to a wholly new assessment system would be difficult to contemplate. In addition, OASIS is the result of over 10 years of research and testing and, therefore, no small cost or effort on CMS's part. We hope that you will consider these issues and allow considerable time and additional resources as part of any major transition.

**Other factors in determining post acute care setting:**

Despite the desire for some uniformity based on a common assessment process, there remain a number of reasons why an individual might go to one post acute care setting as opposed to another and why a uniform assessment tool would not necessarily capture these factors. These include:

- geographic variation in availability of facilities and/or staff;
- prevalence of different post acute care settings in particular regions and their capacity;
- patient and family choice;
- patient's co-morbidities, obesity or cognitive impairments; and
- availability of family or informal caregivers.

**VNAA recommends that the following occur:**

1. The federal government should move forward in developing a uniform assessment process for post acute care where there is overlap in the types of patients served by different types of provider. To achieve that goal, VNAA believes that it is essential to begin comparing patient characteristics, outcomes and payments across all post-acute care settings.
2. To ensure patient choice, patients must be made aware of their options for all appropriate post acute care, preferably in advance of hospital discharge.
3. There is a need to expand opportunities for patients to select home and community-based alternatives to institutional care both as a matter of cost-efficiency and patient preference. In general, patients should go to the least intensive, least restrictive, and least costly setting. This, of course, is dependent on reliable and ongoing data on outcomes and cost-effectiveness. If the same type of care that is provided in a SNF or IRF can be provided in the home at a lesser cost, it would make sense for home and community-based care to be the first consideration in the decision tree for patient placement after hospitalization.
4. Implementation and transition costs of any new process must be considered. The enormous expense of adopting new assessment technologies cannot be ignored. This includes not only the development and testing costs and crosswalks between existing payment and quality systems, but also the additional investments that providers will have to make for new technology and staff training.
5. The development of a system where different providers can electronically access standardized medical records will inevitably require greater uniformity in patient assessment and outcome reporting. Perhaps these efforts could take place simultaneously. Standardized descriptions for assessment could potentially be included in electronic medical records. This would not only achieve economies of scale and reduce duplication of effort, but could lead to ongoing improvement in assessment, evaluation and payment policy.

Thank you once again for the opportunity to testify today. I would welcome the opportunity to respond to your questions.

***For more information, please contact Kathy Thompson or Bob Wardwell at 240/485-1856(5).***

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Chairman JOHNSON. Thank you very much for your testimony.  
Dr. DeJong.

**STATEMENT OF GERBEN DEJONG, SENIOR FELLOW, NATIONAL REHABILITATION HOSPITAL, AND VICE PRESIDENT, AMERICAN CONGRESS OF REHABILITATION MEDICINE, INDIANAPOLIS, INDIANA**

Dr. DEJONG. Thank you, Madam Chairman, Mr. Lewis and Members of the Committee. My name is Gerben DeJong and I am a Senior Fellow at the National Rehabilitation Hospital here in Washington, D.C. I am a clinical and health services researcher. I

do not speak for any organization, constituency or industry here today. I am a long-time student of American post acute health care. I have studied it across all the different industries: IRFs, SNFs, home health agencies and LTCHs. We have been asked to address two main topics this afternoon. One is the development of a common patient assessment tool, and the second is the development of a more rational post acute payment system. I would like to address both of these.

First, with regard to a common patient assessment tool, I believe that we do need a common patient assessment tool. The MedPAC report that came out yesterday really underscores the shortcomings of the present system. What it said is that we have different tools with different purposes with different time periods with different types of clinicians doing the assessments using different scales and addressing sometimes similar, but different domains and using different diagnostic coding. I would caution us against a one-size-fits-all, all-inclusive measure. There is an overlap in types of patients across the four post acute industries, but there is also a great diversity in the types of patients seen in post-acute care. My great fear is that we will end up with a very large and unwieldy assessment tool that tries to be all things to all people. We have already been down this road. Back in 2000-2001, CMS, at that time known as Health Care Financing Administration (HCFA), was trying to come up with an MDS for post-acute care that would eventually apply across all four industries. It included about 400 data elements and 20 pages. I do not think we really want to go there again.

My recommendation would be to keep it simple: Develop a core instrument with the elements that are essential to assessment, payment and outcome; allow for some auxiliary data modules to be added to the core instrument to meet the needs of individual sites and different types of patients, but do not try to impose the whole thing on everybody. It is not going to work; it will be overly burdensome. My written testimony outlines several different steps in developing a more parsimonious, well-grounded, valid, and reliable instrument, and I will not go into that at this time. If Congress and the Administration believe they need to do something quickly and does not have time to do all the development work for a new instrument, I would encourage them to seriously consider the most parsimonious of instruments now in post-acute care and that would be the IRF-PAI as a potential point of departure for a system-wide instrument.

On to payment systems for a moment: Yes, we do have a very irrational post acute payment system with four very different PPS methodologies that differ in terms of unit of payment, type of case-mix adjuster, number of case-mix groups, and type of patient assessment tool. Some of the payment systems, in my view, are very convoluted, especially the SNF-PPS based on the MDS and the Resource Utilization Groups (RUG). I do not know how anyone can live with that particular system. In going forward I would urge caution. First, do no harm. I believe that the post-acute care system has gone through a lot of upheaval over the last decade. We had tremendous consolidation from 1993 to 1997. We went through the managed care revolution in the mid-nineties. We had the Bal-

anced Budget Act 1997 and its long lasting effects. We have had the collapse of several large post acute chains in 1998 and 2000. Some parts of the post acute system are still implementing the PPS. For example, both IRFs and the LTCHs started implementing a PPS as recently as 2002, and LTCHs are still in the process of phasing in their new payment system.

So, what are our options? Our options are really threefold. First is to pick the best of existing post acute payment systems. The leading candidate in my opinion, is the IRF-PPS. I say that in part because it is a function-based system that is aligned with restorative goals of the Medicare post-acute care system. I say it for other reasons as well. I would, even now, add on a pay-for-performance component. Something that is lacking in all four post acute payment systems. The payment systems are supposed to be based on the characteristics of the patients, but it also needs to take into account clinical performance. A second option is to consider bundling acute and post acute payment. That idea has been around for more than 20 years. I think, however, that it poses some very difficult implementation issues, and is likely to have several unintended consequences. A third alternative is to develop an Internet-based bidding system where providers bid for patients on price and outcome with some risk sharing for more difficult patients. I think this option has some promising possibilities that deserve to be explored. I would also encourage the development of one or more demonstration projects as an interim step, and I could perhaps share some ideas, should there be more time to do so. Ultimately, we need an integrated post acute payment system that competes effectively on price and quality. Let me say something about that here.

We talk about payment systems and we talk about patient assessment instruments, but we cannot have an effective payment system unless payment is also linked to quality. What we need is a more effective system of public disclosure of outcomes and quality indicators so that all post acute stakeholders—consumers, family Members, payers, and providers alike—can make the informed choices that they need to make. The CMS has already taken some important steps in this direction, particularly with the nursing home quality initiative and the home health quality initiative, but I think there is still a lot more work to be done in this area. Other than that, I just want to say that when we look at different sites of care, we need not only consider whether or not one site is more effective than another, we also need to consider what actually occurs in the process of treatment and care; what are the active ingredients each site provides. It is not good enough to say that an SNF is better than an IRF or better than home health or whatever the case may be. We need to take that bundle of services apart. We need to find out what really goes on there. What are, in fact, the active ingredients at each site of care? I believe that purchasers and payers alike need to know what it is that they are buying; they cannot be informed buyers unless we peer into the black box and find out what in fact is making the difference in each site of care. Thank you very much.

[The prepared statement of Dr. DeJong follows:]

**Statement of Gerben DeJong, Ph.D., Senior Fellow, National Rehabilitation Hospital**

Good afternoon. My name is Gerben DeJong. I serve as a senior fellow at the National Rehabilitation Hospital in Washington, DC.

I want to thank the Subcommittee for inviting me to testify. I want to make clear that I do not speak for any particular organization, constituency, or industry. I am first and foremost a clinical and health services researcher who has been a long-time student of American post-acute care. I have been tracking industry growth and development in post-acute care for about 25 years. I have tracked the spurts in growth across all four major sectors of post-acute care—inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), home health agencies (HHAs), and long-term care hospitals (LTCHs). I have watched how these industries have waxed and waned in response to the changing needs of Medicare beneficiaries, changes in Medicare payment policy, and the vagaries of the larger national economy.

I should also disclose that I am the vice president of the American Congress of Rehabilitation Medicine (ACRM)—a group of 800 researchers and clinicians devoted to enhancing evidence-based practice in rehabilitation and health care for individuals with disabilities. ACRM is also committed to the concept of evidence-based health policy. Many observers have been critical about the lack of evidence-based practice in health care but the lack of evidence-based policy is equally striking. In this regard, I believe it is important that, when we embark on potential changes in post-acute assessment and payment, these changes be anchored in solid research. I want to compliment the Subcommittee for taking on these difficult topics and hope that, as we move forward, we do so considering all the evidence and, where evidence may be lacking, we defer judgment and garner the evidence still needed.

The Subcommittee has requested that we address two main topics, the development of a common patient assessment tool and a more rational payment system for post-acute care. I will address both and add a couple of additional comments.

**Common Patient Assessment Tool**

Three of the post-acute settings—IRFs, SNFs, and HHAs—have their own patient assessment instrument and a fourth setting, LTCHs, use none for purposes of patient placement, outcome, and payment. I want to express some caution here. There is a presumption in some quarters that there is considerable overlap in the types of patients seen in various post-acute settings and that we need to develop a uniform patient assessment tool to address patients regardless of post-acute setting. I agree that some or similar patients are seen in different post-acute venues, but I would also submit that there is a diversity of patients and that it will be difficult to find or create one tool that can capture the full range of patient need across all settings of care. By trying to create an all-inclusive instrument, we run the risk of developing an unwieldy instrument, many elements of which, will not apply to many patients.

We have been down this road before and backed away. Recall that in 2000–01, the Health Care Financing Administration, now Centers for Medicare and Medicaid Services (CMS), then proposed the Minimum Data Set for Post-acute Care (MDS–PAC) as uniform instrument for all post-acute settings as the basis for both payment and quality monitoring. This effort failed for many reasons but the chief among them was that the MDS was a huge instrument (20 pages) that consisted of over 400 data elements many of which simply did not apply to the care and management of many patients. It was anything but “minimum” and it was a clear case of overreach in an attempt to develop a one-size-fits-all instrument.

If we choose to go forward in developing a common patient assessment tool—and I would recommend that we do, I would make several recommendations:

1. **Purpose.** Be clear as to what the patient assessment tool is for. Is it for making post-acute patient placement decisions? For determining payment level? For quality monitoring? For developing quality indicators that payers and consumers can use in making informed choices? For all of the above?

2. **Theoretical framework.** Choose a theoretical or conceptual framework that is consistent with the purpose of the Medicare-supported post-acute care. The purpose is restorative care, not custodial care. Yet, MDS 2.0, for example, is replete with references to the “resident” and contains a strong custodial or nursing home bias that is not congruent with the functional enhancement goals of rehabilitation. Medicare does not pay for custodial nursing home care.

3. **Parsimony.** Do not try to develop an all-inclusive, one-size-fits-all instrument. Focus on some core variables or indicators of patient need, progress, and outcome. If one were to build on an existing patient assessment instrument, consider using

the IRF-PAI as the point of departure, not the MDS. The IRF-PAI is the most parsimonious of the three post-acute patient assessment instruments.

4. **Validity and reliability.** Test for relevance, clarity, validity, inter-rater reliability, internal consistency, redundancy, and respondent burden. These are fundamental instrument development steps many of which were not satisfactorily addressed when the MDS was developed. Consumers, taxpayers, and providers alike expect instruments to provide a valid and reliable basis for patient care and the payment of public dollars. The careful scientific process of validity and reliability estimation must be completed before a new instrument is implemented for an entire post-acute system. The implications of a common assessment instrument are too far-reaching to short-change these instrument development processes—especially when we are talking about the allocation of more than \$30 billion of Medicare resources.

5. **Computer-aided “dynamic assessment” technologies.** Consider using computer-aided dynamic testing technologies that enable one to measure functional status using fewer data points. We have already greatly reduced respondent burden in the administration of well-known tests such as the SAT and the GRE by using computers to vary the degree of difficulty each question presents and then pin-pointing the respondent’s capacity based on this hierarchy of difficulty without having to ask each question. We can do the same in post-acute functional assessment because there is a hierarchy of functional tasks where the ability to do one task presumes the ability to complete less demanding tasks. Such technologies allow us to address a broader range of human function across more settings of care than a setting-specific instrument that may present “floor” or “ceiling” problems for another setting of care. Some excellent work in this area is occurring in places such as Boston University, Northwestern University, and the University of Florida.

***If the Subcommittee or CMS believes that it needs to proceed more quickly in implementing a uniform patient assessment instrument, I would strongly recommend using the IRF-PAI with only modest changes.*** Some SNFs and LTCHs already use the FIM embedded in the IRF-PAI and thus are already familiar with the functional concepts that undergird the IRF-PAI.

#### **Rational Post-acute Care Payment System**

Apart from care obtained from outpatient centers, each of the four major post-acute settings of care has its own payment system. From a system-wide point of view, the current multi-setting payment system appears irrational and reflects as much about the setting of care as it does about the patient. Moreover, there is a concern that we are using different payment systems when patients in one setting of care may, in some instances, be similar to patients in other settings of care. At another level, the current state of affairs is not as irrational as it may appear since each payment system contains features that speak to the strengths and traditions of each setting. The accompanying table compares each of the four post-acute payment systems in terms of their unit of payment, case-mix adjuster, number of case-mix groups, and effective dates of implementation following the passage of the Balanced Budget Act of 1997 (BBA’97) and the Balanced Budget Refinement Act of 1999 (BBRA’99). To date, we have had research that examines the effects of individual payment systems but no research that attempts to look at the interactions across all four systems especially at the market level in terms of their effects on market entry and exit, market supply and mix of facilities, within market referral patterns, access, patient case-mix, utilization, and practice patterns across all four settings.

In going forward, I would argue for proceeding cautiously and carefully. First, do no harm. I say this because payment systems can result in unintended consequences that may be adverse to the needs of patients and the overall system and cost of care. Over the last 8 years, the nation’s system of post-acute care has undergone tremendous upheaval some of which came in the wake of managed care in the 1990s, the BBA’97, and also with the collapse of several large provider chains from 1998–2002. More upheaval and instability are not what this sector needs in its immediate future. Some venues such as IRFs and LTCHs began implementing their respective PPSs as recently as 2002 following years of research, development, and planning that proved arduous for both CMS, its contractors, and the affected post-acute industries.

In developing a more integrated post-acute payment system, there are several options, some of which will require several years of careful work and implementation.

The most immediate option is to take the best of the existing post-acute payment systems and apply it to the other settings of post-acute care—with perhaps some additional features such as a pay-for-performance provision. ***The leading candidate among the existing payment systems is the function-based IRF-PPS.*** As a function-based system, it is perhaps best aligned with Medicare’s restorative

model of care and would relieve SNFs, for example of its awkward and burdensome MDS and RUGs-based PPS that is derived from a more custodial model of care.

### Prospective Payment Systems for Post-acute Care

Feature	Inpatient Rehabilitation Facilities (IRF-PPS)	Skilled Nursing Facilities (SNF-PPS)	Home Health Agencies (HHA-PPS)	Long-term Care Hospitals (LTCH-PPS)
<b>Unit basis</b>	Per case / per hospitalization	Per diem <sup>1</sup>	Per 60-day episode of care	Per Case / per hospitalization
<b>Case-mix adjuster</b>	Function-related groups (FRGs) or case-mix groups (CMGs)	Resource Utilization Groups III (RUGs III)	Home Health Resource Groups (HHRGs)	Diagnosis-related groups (DRGs) specific to LTCH patients
<b>No. of case-mix groups</b>	95CMGs X 4 comorbidity subgroups / CMG = 380 groups	44	80	540
<b>Input document / information Source</b>	Patient Assessment Instrument (IRF-PAI)	Minimum Data Set (MDS) <sup>2</sup>	Outcome & Assessment Information Set (OASIS)	ICD-9-CM codes recorded on pt claims
<b>Effective dates &amp; phase-in period</b>	Jan 2002 67% or 100% Oct 2002 100%	1999 25% 2000 50% 2001 75% 2002 100%	Oct 2000 100% (no phase-in period)	Oct 2002 20% Oct 2003 40% Oct 2004 60% Oct 2005 80% Oct 2006 100%

<sup>1</sup>Based on assessments made on the 5<sup>th</sup>, 14<sup>th</sup>, 30<sup>th</sup>, 60<sup>th</sup>, and 90<sup>th</sup> days after admission to a SNF.

<sup>2</sup>The MDS is completed on the 5<sup>th</sup>, 14<sup>th</sup>, 30<sup>th</sup>, 60<sup>th</sup>, and 90<sup>th</sup> days after admission to a SNF.

What the IRF-PPS lacks, however, is an explicit incentive for outcomes and performance. The IRF industry already has many of the requisite measures that can be used as the basis for a partial payment that is linked to performance. I could envision a system in which a part of each facility's payment might be tied to specific performance measures on either an individual patient basis or on the basis of the facility's aggregate performance on patient outcomes.

There are many other potential integrated post-acute payment systems. The concept of "bundling" acute and post-acute payment has been around for more than two decades although I believe it has significant implementation problems. Another alternative is to construct an Internet-based bidding system in which providers might bid for patients on the basis of price and outcome with some risk-sharing to induce providers to take on the most difficult patients. All of these different systems require advanced thinking, research, and planning.

The Subcommittee and CMS should also consider sponsoring one or more demonstration projects. For example, CMS should consider how multiple levels of care might be provided in a step-down fashion within a single provider system that cannot be fully accommodated within the existing silo-by-silo post-acute payment system. One of the challenges we now have is that a patient may start at one level of need at the outset of their post-acute experience but may require a very different mix of services as he or she progresses. The challenge is to design a payment system that allows a single provider system to better optimize the mix of services over time in a way that provides continuity of care, maximizes outcome, and minimize costs.

Ultimately, we need to work toward a more integrated market-based system that competes effectively on both price and quality. Making health care conform to market-based principles has bedeviled even the most ardent advocates of market-based health care including myself. When patients are in medical crisis, they or their family members are not always price sensitive nor do they always know how to get the information to make choices they need to make in selecting a provider or course of care and often depend on the advice of their physician, other family members, or friends. Moreover, their choices are often preempted by the decisions of third-party payers who may have prearranged provider networks that limit choice.

Nonetheless there are steps that can be taken regardless of the payment systems that might evolve in the years to come. One key to any reform is effective quality

competition that will allow providers to compete on quality as well as price and mitigate the potential effects of stinting that may result from fixed payment systems.

Central to such competition is the public disclosure of outcomes and quality indicators that will enable payers, consumers, and family members to make the post-acute choices they need to make. This clearly takes us back to the issue of a common patient assessment system. In its 2001 landmark report, *Crossing the Quality Chasm*, the Institute of Medicine identified 10 cardinal rules to govern the transformation of the American health care system. Rule 7 is the need for transparency:

“The health-care system should make information available to patients and their families that allow them to make informed decisions when selecting a health plan, hospital, or clinical practice or choosing from among alternative treatments...”

Fortunately, some steps in this direction are already being taken in both acute and post-acute care. In post-acute care, CMS has launched the Nursing Home Quality Initiative, which provides 10 quality measures on every nursing home in the nation. One can now go to the Web and check any nursing home’s performance on these 10 measures. CMS is continuing to develop an analogous Web-based quality initiative for the home health industry.

The current indicators for nursing home and home health care are only a start. They are fairly crude and not adequately sensitive to the functional restoration goals of post-acute care. CMS and its companion agencies in the federal government need to capitalize on the functional status and outcome measures already used in rehabilitation and consider their applicability to other portions of the post-acute care system. They are not perfect and much work needs to be done.

The development of an effective integrated post-acute payment system requires the development of outcome measures and quality indicators that are publicly disclosed and support decision making by all post-acute care stakeholders. There are several steps that CMS and its companion federal agencies, e.g., AHRQ, can start to take now that will serve the needs of future integrated payment system regardless of the exact payment system chosen. CMS needs to foster buy-in across the different types of post-acute providers that a quality-indicator and outcome disclosure system is in fact needed and is integral to the development of an integrated payment system. And working with all post-acute stakeholders, including consumer groups, CMS needs to create rules for a fair outcome disclosure system that provides for a level playing field among providers. This includes consensus on standardized reporting methods, research on risk—or case-mix adjustment, and methods to prevent gaming and cheating. Finally, CMS needs to test multiple reporting formats that will make the information usable for different stakeholders.

#### **Other Issues Related to an Integrated Post-acute Care System**

Lurking behind the discussion of the need for a more integrated post-acute system of care are issues and concerns that I believe need to be reframed if we are to have a more informed discussion about the future of post-acute care. For example, there is an abiding concern that the same kinds of patients are being served in multiple settings, some at lower costs than in other settings, with similar outcomes. As a researcher, I am especially concerned that we are not always comparing apples with apples and oranges with oranges particularly in our characterizations of patient populations and in our computation of costs associated with each site of care. This testimony is not the venue to go into the particulars but I would urge caution.

These issues come into their sharpest focus when we address questions regarding the efficacy of care for certain patients in one setting versus another as in the case of IRFs versus SNFs. We usually frame the question as follows: Do stroke patients do better in an IRF or a SNF? Do joint replacement patients do better in an IRF or a SNF? Instead, we need to ask which stroke patients do better in an IRF and which do better in a SNF? Or, which joint replacement patients do better in an IRF or in a SNF? One’s research may find that one setting or another does consistently better with one patient group or subgroup than another but we should not start with the presumption that one setting has an exclusive franchise with a particular impairment group.

In examining the differences in outcomes and costs between IRFs and SNFs, we also need to ***be able to characterize the differences in the care received in these two settings***. One needs to look at all interventions and processes of care from basic medical support to individual therapies. Moreover, one needs to characterize these differences in terms of *timing, intensity, frequency, and duration*. Without these characterizations, both settings remain black boxes and prudent purchasers, both government and health plans, cannot fully know what it is that they are purchasing. Nor can they discern the active or inactive ingredients in the IRF and SNF rehabilitation process that shape outcomes. Purchasers and providers

alike, need to know which clinical activities and interventions make the biggest difference for which patients and in what setting these activities and interventions are most likely to be found. It is not enough to say one setting is more effective than another without stating what it is about that setting that accounts for difference.

Most controversial at this time is the best venue for the post-acute rehabilitation of joint replacement patients especially in the wake of the 75% rule that requires IRFs to have 75% of its patients come from one of 10–13 impairment groups (10 under the old rule; 13 under the new rule). Over the last decade (1994–2003), the number of joint replacement patients discharged from acute care hospitals increased 51%, from 241,410 to 364,824 patients and a corresponding increase has been seen in post-acute care. If we are to have an effective integrated post-acute system of care, we will still need to sort out which patient groups and subgroups do better in one setting versus another. In short, there is a huge need to conduct research that will enable us to refine the placement and treatment decisions in post-acute care even if we are to achieve a more integrated system of post-acute assessment, placement, treatment, and payment. In fact, answering these types of questions is essential to a more integrated post-acute system. CMS and its companion agencies need to make a significant investment in the research that can undergird a more rational system.

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Chairman JOHNSON. Thank you very much. Dr. Votto.

**STATEMENT OF JOHN VOTTO, PRESIDENT AND CHIEF OF STAFF, HOSPITAL FOR SPECIAL CARE, NEW BRITAIN, CONNECTICUT, ON BEHALF OF THE NATIONAL ASSOCIATION OF LONG TERM HOSPITALS**

Dr. VOTTO. Thank you, Madam Chair, and Congressman Lewis, for inviting me here today to speak on these very important issues. I am here representing the Hospital for Special Care and the National Association of Long Term Hospitals. My name is John Votto. I am a practicing pulmonary physician; I have been practicing for approximately 20 years at the Hospital for Special Care and the Veteran's Affairs (VA) hospital in Connecticut. I am currently President of the Hospital for Special Care and Chief of Staff, and I am active in the National Association of Long Term Hospitals in the sense that I am Chairman of the Physician Committee and the Criteria Development Committee. The Hospital for Special Care is a 228-bed LTCH which has been around for 65 years. During that time, we have developed our programs based on the community needs in the area. Our major programs are those of ventilator weaning, brain injury, complex medical, wound care, and pediatrics. We also have a spinal cord injury program, which is the only Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited program in the State of Connecticut. The hospital also operates a 282-bed nursing facility, SNF, and so I feel that I am keenly aware of the issues that are talked about at this meeting. I know that the Committee is very concerned about overpayments and inappropriate payments, and so in this regard I will have some comments. In regards to the patient assessment tool for LTCHs, as we have all heard, we don't have our own patient assessment tool, and the rehab hospitals do, the SNFs do. These, I don't feel, are appropriate for the LTCH industry, having done both of these things and been involved in both of these things. I do believe, though, that data does exist which could help develop a patient assessment tool for the LTCH industry.

One of the things that we recently did in the National Association of Long Term Hospitals is we just completed a two-year study looking at 1,419 ventilator-dependent patients who came to LTCHs especially for weaning. They came from 23 different LTCHs across the country. We did not direct how they were weaned, we just directed that they came in for weaning. This is a prospective study. What we did was look at many outcome measures, including time to wean, length in the acute care hospital prior to discharge to the LTCH, mortalities, outcomes, functional status, and many, many other things that we have studied. In addition, we also looked at the cost of care, and in 963 of these patients we were able to come up with costs of care and get the data that included that. During the course of the study we did share some of this outcome data with CMS and MedPAC. I believe, though, that the results of this study would be at least some basis for developing a patient assessment tool, and I think that, given the way this study was done, we could develop patient assessment tools for other programs and other diagnostic categories like wound trauma and medically complex.

We are obviously interested in the appropriateness of the patient setting and the appropriateness of care, and I believe that in the short term, QIO review is probably the best remedy to do that. The QIO did review only 1,400 cases, as many of you know, in 2004, and there was a very high denial rate, indicating that maybe there was inappropriate placement of certain patients. I don't believe that 1,400 cases across the entire industry in 1 year is probably a good measure. The example given of the hip fracture patient where the payments were so different, I don't know if they took the short-stay policy into account in the LTCH that the LTCH industry has in place, but I can assure you that the Hospital for Special Care, first of all, rarely admits these types of patients because they have to have uncontrolled diabetes, uncontrolled congestive heart failure, or other things before we would take that patient, but I can assure you that we aren't getting \$44,000 for that patient. Although I am very much in favor of the QIO review, I think that the screening process could be improved. I don't believe that the criteria sets that are available now are aligned with the PPS that we have right now.

MedPAC's report to Congress did indicate that screening criteria were a priority, and we have at the National Association of Long Term Hospitals just completed the development, after 2 years, of screening criteria which we feel are quite good and appropriate for the industry; we are in the process of having professional validation this summer, and should have that completed by this fall. We have also shared drafts of these criteria with MedPAC and CMS. In the long term, I believe the Secretary should participate in the construction of a database which, if the work was done with MedPAC and the industry, probably could be very helpful in developing a patient assessment tool. I am concerned about the payment systems, the combinations and the difficulties of counting Medicare days and overlap of patients. This could be a very difficult problem, as has already been noted, but I think it probably could be overcome, and we could develop a patient assessment tool. In conclusion, I think in the short term QIO and screening criteria could

stabilize at least the payments to LTCHs, and, in the long term, a comprehensive database, which I believe may have to be done with more than a 5 percent sample, which is what is proposed, could be used as a patient assessment tool or help in the development of a patient assessment tool. Thank you for your attention.  
[The prepared statement of Dr. Votto follows:]

**Statement of John Votto, D.O., National Association of Long Term Hospitals, New Britain, Connecticut**

Chairman Johnson and members of the Subcommittee, thank you for inviting me to speak before you today on the important questions presented in the notice of this hearing which concern the status of assessment tools and payment issues related to long-term care hospitals and other post acute Medicare providers. My name is John Votto. I am a physician with a specialty in pulmonary medicine. For the past seventeen years I have practiced medicine at the Hospital for Special Care in New Britain, Connecticut. Currently I am the President of the Hospital for Special Care and also maintain an active practice caring for patients at the Hospital. Additionally, I care for pulmonary patients at the Veterans Hospital located in Newington, Connecticut. I am active in the National Association of Long Term Care Hospitals and serve as the Chairman of the Association's Physician Committee and Committee on Criteria Development. The hospitals which comprise the National Association of Long Term Hospitals account for approximately one third of all Medicare beneficiaries who receive services in long-term care hospitals. While many of my remarks today are made on behalf of the National Association of Long Term Care Hospitals they also relate to the Hospital for Special Care. The Hospital for Special Care is a relatively large long-term care hospital with 228 beds and an active outpatient department. The hospital provides a wide range of clinical services, including ventilator weaning services to patients who have complex medical care needs. The hospital provides rehabilitation services and maintains the only certified spinal cord injury unit in the State of Connecticut. The Hospital for Special Care also operates a free standing 282 bed skilled nursing facility. Accordingly, I am keenly aware of the issues related to the appropriateness of services provided to inpatients in the settings which are the subject of this hearing.

The focus of this hearing is to explore issues related to the establishment of patient assessment tools and particularly a common assessment tool which could be used across post-acute Medicare provider types. Additionally, I understand the Committee is concerned that the Medicare program makes inappropriate payments where patients who require the same or similar medical resources receive care in different Medicare provider settings at different rates of payment. The National Association of Long Term Hospitals strongly supports the creation of appropriate patient assessment tools and the use of safeguards which assure that Medicare beneficiaries receive care in the most appropriate cost effective and safe setting. I will focus my specific comments on these questions by reviewing policy initiatives that the Medicare program could undertake in both the short and long term to achieve these goals.

***Actions the Secretary can undertake now***

The National Association of Long Term Care Hospitals is unaware of any ongoing activities which have been undertaken by the Secretary to establish a patient assessment tool or patient outcome measures for patients who use long-term care hospitals. The patient assessment tools which currently exist for other types of post acute hospital providers are not adequate to assess patients who receive care in long-term care hospitals. The Minimum Data Set (MDS) which is used as an assessment tool for skilled nursing facilities does not measure physician directed services and related medical complexity of hospital level patients. The MDS measures routine care needs of patients on a per day basis and, therefore, can only be used with a per diem payment system. Long-term care hospitals and inpatient rehabilitation facilities are reimbursed by the Medicare program on a per discharge basis and not on a per diem basis. Functional related groupings (FRGs) which are used by inpatient rehabilitation facilities contain functional measures and are not appropriate for the medically complex cases which are admitted to long-term care hospitals.

Studies and data do exist which the Secretary could consider to establish a patient assessment tool for Medicare beneficiaries who use long-term care hospitals. For example, a significant segment of patients admitted to long-term care hospitals are in respiratory failure with ventilator support. The National Association of Long Term Care Hospitals is sponsoring a study of the characteristics of these patients,

including ventilator weaning rates. The final report on this study is expected in a few weeks. This multi-site study was conducted by the Barlow Respiratory Hospital Research Center which is located in Los Angeles, California. The study included data on 1,419 patients who were admitted to 23 long-term care hospitals located throughout the country with active ventilator weaning programs. The study contains survey instruments and outcome data which could readily be considered in the development of an assessment instrument which then could be applied across all post acute Medicare provider types. This data include:

1. Days on a ventilator prior to admission to a long-term care hospital.
2. Demographic and patient characteristic data such as sex and pre-morbid domicile;
3. Pre-existing co-morbid diagnoses and comorbidities.
4. Patient location prior to admission (e.g. ICU, step-down or monitored unit, rehabilitation unit).
5. Patients with and without a surgical procedure;
6. Length of stay in transferring hospital;
7. Percentage of cases admitted with single and multiple pressure ulceration together with stage and description of ulcer;
8. Functional status at the beginning and end of a long-term care hospital stay: Zubrod score.
9. Procedures and treatment provided at the long-term care hospital or on a "same day" basis at an acute care hospital.<sup>1</sup>
10. Complications arising at the long-term care hospitals by frequency of occurrence.
11. Outcome of long-term hospital stay, i.e. weaned, ventilator dependent, deceased.
12. Hospital specific cost of care based on cost to charge ratios.
13. Twelve month post admission status.

During the course of conducting this study the National Association of Long Term Care Hospitals provided CMS, as well as MedPAC, with interim reports and study outcome data. The Secretary could consider the results of this study in developing a patient assessment tool for ventilator dependent patients who are admitted to long-term care hospitals and perhaps other post acute Medicare provider settings. The data which have been collected and analyzed on patient functional status as well as ventilator weaning rates may also provide a basis for outcome measures. Moreover, the Secretary could consider whether these same data should be used to study whether patients admitted to any other classes of post acute Medicare providers have similarities to those admitted to long-term care hospitals.

The Secretary could also make an assessment whether the data collection instrument used in this study could form a basis to collect data for wound care, cardiac, and other classes of patients admitted to long-term care hospitals. I wish to underscore that a basic patient assessment tool which records data including patient diagnosis, comorbidities, functional status on admission and discharge as well as readmission rates, should be attainable by the Secretary within the short term.

I now wish to turn my attention to the very important question of the appropriateness of placement of patients in post acute care providers and in particular in long-term care hospitals. This issue is at the heart of the Medicare payment questions presented in the notice of this hearing. It is important that at least since the early 1990s, until 2004 the Secretary has omitted from the annual scope of work for Quality Improvement Organizations ("QIO"), review of the medical necessity and appropriateness of services provided to Medicare beneficiaries in long-term care hospitals.

Historically there has been no ongoing professional review of whether patients selected for admission to long-term care hospitals required medical resources of the type and frequency which are provided in another, lower cost setting. As part of implementation of the long-term care hospital prospective payment system the Secretary included review responsibilities for the appropriateness of admission to a long-term care hospital for a small sample of 1,400 Medicare cases in the QIO scope of work for 2004. The reported denial rate from this review process was 29%. The Secretary has retained this small sample size for the 2005 QIO scope of work. The denial of a patient admission by a QIO means there has been a finding that the patient could have been treated in a lower cost more appropriate Medicare provider

<sup>1</sup>All "same day" services received by long-term care hospital patients are "bundled" within the long-term hospital DRG and remain the financial responsibility of the long-term care hospital. The cost of acute hospital services for these patients is not separately billed to the Medicare program.

setting such as a skilled nursing facility or by a home health agency. In every case where there is a final denial by a QIO the long-term care hospital receives zero payment for the case at issue. The National Association of Long Term Care Hospitals has closely followed the review of Medicare cases by QIOs and believes that QIOs can effectively and efficiently distinguish between cases that require the medical resources and programs provided by long-term care hospitals and those provided by, for example, skilled nursing facilities. The differences in payment across post acute settings recited in the notice of this hearing do not consider the effect of QIO review and especially the effect of continued stay review on payments to long-term care hospitals. The example given is a \$44,633 payment to a long-term care hospital for a hip fracture while payments to a rehabilitation facility and skilled nursing facility would be significantly less. The long-term care hospital prospective payment system has a short stay payment policy where patients with stays less than 5/6<sup>th</sup> of the geometric mean length of stay for the applicable LTCH-DRG are paid on a per diem and not a full case basis. The Secretary may properly consider expanding QIO review responsibilities to include the appropriateness of continued stay and discharge. This would result in review for medical necessity and length of stay the two factors which effect payment under the long-term care hospital prospective payment system.

I do wish to point out an important area where review by QIOs could and should be improved. QIOs use "screening criteria" to differentiate cases which can be approved by nurse reviewers from those which are referred to physicians for further review. Commercially available screening criteria authorize a patient discharge whenever a patient, during a stay qualifies under a criteria set for another provider type. These screening criteria sets are not designed to be used for payment purposes. One of the objectives of a prospective payment system is to include the full course of care within fixed LTCH-DRG reimbursement. MedPAC review of long-term care hospitals together with its report to Congress in June of 2004 focused the National Association of Long Term Care Hospitals on the need to develop appropriate screening criteria for the Medicare program. The National Association of Long Term Care Hospitals over a two-year period, has developed long-term care hospital screening criteria and is in the process of engaging in a professional validation of these criteria.<sup>2</sup> The Association has shared drafts of these criteria with the Subcommittee staff, both CMS and MedPAC. Current care plans are to present the criteria for review by payors, including the Medicare program, on a pilot basis this summer. Final validation is projected to be concluded in the fall of this year.

***Longer term steps actions and issues***

In the longer term the Secretary should participate in the construction of a post acute data base which would allow for the establishment of a post acute patient assessment instrument. A valid post acute assessment instrument is an essential prerequisite to the establishment of a patient classification system which, in turn, 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. The National Association of Long Term Care Hospitals understands that MedPAC has established a post acute data base which is comprised of a 5% sample of Medicare beneficiaries who are discharged to post acute providers. The Association recommends that this sample size be expanded as it is unlikely that a sufficient number of discharges from long-term care hospitals are included in the data set. Expansion of the data set is necessary to establish a common patient assessment tool. The Secretary should consider working closely with MedPAC and industry representatives in the establishment of this data base to ensure that assessments made under a uniform payment system are appropriate and feasible.

Finally, I wish to point out that a merger of payment systems could present a host of policy challenges. For example, the Medicare program provides different benefit day coverage depending on whether a beneficiary receives services in a hospital or skilled nursing facility. Also, the placement of a beneficiary in a skilled nursing facility triggers a new co-insurance obligation. Currently, if a patient remains in a hospital at a skilled nursing facility level of care waiting placement in a skilled nursing facility, days of hospital service are not counted toward the limited 100 day skilled nursing facility benefit. If the beneficiary has not reached DRG cost outlier status, days of care in excess of those used to reach the geometric mean length of stay for the applicable DRG are not countable towards the beneficiary maximum hospital day benefit of 150 days. These policies exist for the fundamental reason that it is important to include as much services as is reasonably possible and appro-

<sup>2</sup>These criteria sets include: cardiovascular, complex medical, respiratory, ventilator weaning, wound care and rehabilitation.

appropriate in a fixed per discharge DRG payment system. Skilled nursing facilities are reimbursed on a per diem payment system where, unlike day of care in a hospital, beneficiary days are counted on a consecutive day basis. Additionally, due to the per discharge basis of the long-term care hospital and inpatient rehabilitation facility prospective payment systems, the Medicare program does not make an additional payment when a patient stay qualifies for full DRG payment. There is no additional payment until the patient qualifies for high cost outlier payment. The per diem nature of the skilled nursing facility payment system results in payment for each day of care. It is important that any future changes to post acute payment systems carefully consider consequences to the count of beneficiary benefit days, beneficiary co-insurance liability and the no payment zones which exist under current patient discharge based long-term care hospital and rehabilitation hospital prospective payment systems. I have included as Attachment A to this statement a number of similar issues related to the potential integration of post acute payment systems.

I wish to thank you again and the Committee's staff for inviting me here today and for your courtesy and attention to these important questions.

#### **Attachment A**

#### **Questions Related to Merger of Post-Acute Providers and Payment Systems**

1. **What are the payment objectives of the policy?** Should budget neutrality be preserved within each payment system and if not then across all affected payment systems.
2. **Which provider types are included in this policy initiative?** NALTH assumes long-term care hospitals, IRFs and SNFs are included. Should psychiatric hospitals and units also included? Patients admitted to all of these provider types may, during a stay, have characteristics of patients admitted to one of the other provider types. For example, patients who access an IRF or long-term care hospital and who are at an appropriate hospital level of care upon admission may at the end of a stay or intermittently during a stay appear to be at a SNF level of care. These patients, however, use and require hospital resources (physician and, many times, hospital technology). Also, based on Medicare claims data patients may appear similar across settings at times during their stay but in fact, may be treated very differently during the stay as a whole. These patients benefit from hospital resource use to maintain and improve their health status and, importantly, to maintain functional and clinical stability upon discharge. This is consistent with MedPAC finding that patients who access long-term care hospitals have a 26 percent lower acute hospital readmit rate than patients who do not access long-term care hospitals.
3. **What administrative data, or alternative special instruments, would be used to identify patients (or portions of stays) which overlap between provider types, i.e. LTCH, SNF, and IRF?** The current administrative data which is available to the Medicare program are: cost reports, Medpar files etc. Examples of special instruments are the MDS and FRGs. Existing administrative data and special instruments do not appear to be designed or adequate to identify or define patients subject to the new policy. Also, these data/instruments are not reported on a timely basis for the policy to operate efficiently. A brief example is the MDS which does not collect information on physician interaction but, instead is directed at routine care needs of nursing home patients. NALTH understands the MDS is only compatible with a per diem and not per discharge payment system.
4. **Consideration of the proper accounting of benefit days?** The Medicare program accounts for benefit days based on the provider type where a beneficiary receives services. Days are assigned to a beneficiary's Part A hospital benefit based on days spent in a hospital. If a beneficiary uses SNF services in a hospital these days accrue toward the limited hospital day benefit and not the SNF benefit. The program allows beneficiaries to remain in a hospital while they are at a SNF level of care to allow for a nursing home search. It is widely known that some of these patients will never be placed in a SNF due to, e.g. infectious and behavioral issues. A new Medicare policy which pays days spent in a hospital as SNF services, must carefully consider the effect on the accounting of benefit days, co-insurance and deductible amounts. Payment for these services as provided in a hospital as SNF services would seem to result in substitution of SNF benefit days for hospital benefit days. If so, beneficiaries would be required to pay additional co-insurance and may have a reduction in total available Part A days. Also, beneficiary days are counted consecutively when providers are paid on a per diem. The count of beneficiary

days is suspended in a hospital when a beneficiary has reached the geometric ALOS for the applicable DRG and is only resumed when the patient qualifies for cost outlier status. **The interaction of a per discharge per diem payment system could reduce part A coverage days and also has implications for the time of exhaustion of benefits and related liability for supplemental payments, including beneficiary personal liability.**

5. **Will relative weights of PPS systems and other PPS payment adjusters be affected by a change in payment policy?** A policy which transports payment between payment systems e.g. paying an IRF or long-term care hospital at a SNF rate for some patients or portions or stays would seem to distort payment weights and, as a related issue, budget neutrality within PPS payment systems. We believe that a deviation from established PPS payment rates would result in consistent underpayment of hospital resources. Similarly, a policy which paid SNFs at hospital rates would distort and overpay SNFs by making payments which reflect hospital resources. It is important that federal law imposes different Medicare certification requirements and related costs on hospitals and SNFs. NALTH believes it is important that any new policy not distort PPS payment weights. As a related matter it is important to consider how PPS adjusters, which are not uniform across payment systems, would be affected. For example, IRFs are entitled to a DSH adjustment while long-term care hospitals and SNFs are not. The loss required before cost outlier payments accrue is after other applicable PPS adjusters, which are different depending on provider type and may or may not include DSH, IME and a loss threshold have been reflected in payments due to a provider. If a LTCH or SNF is paid at IRF rates could those rates be inclusive of DSH and other IRF adjustments?

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Chairman JOHNSON. Thank you very much. Ms. Rice.

**STATEMENT OF PAT RICE, PRESIDENT AND CHIEF OPERATION OFFICER, SELECT MEDICAL CORP., MECHANICSBURG, PENNSYLVANIA**

Ms. RICE. Thank you, Chairman Johnson and Committee Members, for allowing us to talk about the post-acute care continuum today. I have had about 37 years of health care experience as a Registered Nurse (RN) and also as a health care administrator, and during that period of time have worked in a number of the post-acute care continuum facilities, including 20 years in inpatient rehabilitation, 2 years in hospital skill-based centers, and 9 years in LTCHs. I am currently the President of Select Medical Corporation. We operate 99 LTCHs across the country, and we also operate Kessler Rehabilitation Hospital in New Jersey. So, we have a large amount of experience both in LTCHs and in rehabilitation. I also speak on behalf of the Acute Long Term Hospital Association that represents over 300 LTCHs all across the country, with Select and also Kindred Healthcare being a large portion of their membership. Kindred operates the third largest number of SNFs across the country as well. So, I have quite a bit of experience, as you might see.

First of all, I would like to address what we believe are the guiding principles and the—as you look at the post-acute care continuum is, with that first guiding principle being that there really is a distinct and unique difference in each of the sectors in the post-acute care continuum. Policy should seek definition of these distinct roles based upon patient characteristics, patient clinical characteristics, and patients' needs. The LTCHs provide care to a very small segment of the acute care patient population, patients that are very high in severity of illness that have multiple complex

medical conditions. These patients require a very intense level of intervention during the healing process. The LTCH patients are less than 1 percent of the Medicare beneficiaries discharged from general acute care hospitals. They are the patients with the highest severity of illness regardless of diagnosis, and are nearly four times more likely to be admitted to an LTCH because of the severity of their diagnosis.

Certainly, IRFs serve a very important role in the post-acute care continuum, providing comprehensive, goal-directed rehabilitation in a team format, with the access to physiatrists to be able to make very aggressive decisions about care on a short-term basis. The SNFs also provide a very important role in the post-acute care continuum through the provision of restorative care, through skilled nursing and also through skilled therapy. There are some similarities in these venues of care, but there are more differences than there are similarities. The differences include the reason for patient admission, the severity and acuity of the patient that is being admitted to each one of these levels of care, the risk of mortality, the intensity of monitoring and of services that the patients require, the type and availability of services that are available in each venue; and also the knowledge, specialization, and the amount of time that is afforded patients based on the patients' actual individual needs.

So, we do believe that there is a difference in the level of care. That difference in regulatory requirements has not been outlined as significantly as it should be, and because of that, you do see some overlap within the treatment that is provided. Not only would we recommend that there be patients' differences outlined, that separate what these sectors of care are, but we also recommend and agree with the development of a common, comprehensive patient assessment instrument that could differentiate the appropriate level of care for patients, as well as determining which patient should go into a specific level of care. Currently, there does not exist a common, comprehensive patient assessment tool that would adequately reflect the complexity of care and the acuity of care of the LTCH patient. Now, certainly, LTCH patients are assessed. They are assessed at the time of admission by physicians and by the team that is caring for them, but there is not an instrument that is provided. We would recommend that an instrument be developed that addresses the complexity of those patients as well as clearly differentiating that.

We also do believe that the third guiding principle should be that the patient should be cared for and paid for in the appropriate setting. If a patient meets SNF criteria, they should not be cared for in an LTCH, but right now there is not specific criteria out there. The only regulatory requirement for LTCHs is that you have a 25-day length of stay. That 25-day length of stay does not indicate the complexity of the care that the patients require or the specific patients that should be admitted to the LTCH as well. There has been much made about the patient that has a fractured hip and what level of treatment they should go into. I want to specifically talk about the stroke patient. You cannot look at diagnosis alone as you look at where a patient can go. It is much more complicated than the 13 diagnostic categories that the IRFs have to contend

with. It is very complicated in which specific locale the patient should be admitted to. The stroke patient that leaves the acute care hospital that has unstable blood sugars requires very frequent monitoring as far as an RN is concerned; that requires a higher ratio of RNs in a facility than might be required in an SNF. That patient could potentially be on dialysis because they also have renal failure, be receiving respiratory treatments, or even potentially be on a ventilator. Those patients clearly are patients that should be cared for in a long-term care facility, an LTCH. The stroke patient that would be most appropriately cared for in an IRF, is a patient that can tolerate 3 hours of therapy a day, is essentially relatively stable, and is able to participate in therapy and is able to make progress toward being able to go home. Another stroke patient with a specific diagnosis that should be considered for either an SNF or being treated at home is the patient that, as far as an SNF is concerned, is the stroke patient that cannot participate in three hours of therapy, still requires therapy, or potentially has a cognitive disability that does not allow learning or comprehension or follow-through. Those patients clearly should not go to an LTCH and should not go to a rehab hospital. Certainly, if the patient can be cared for at home by their families, that is the situation where they should be cared for. So, we do believe that a system should be developed that clearly outlines who the patients are, what their needs are, and where they should go for treatment. That decision should be made by the physician and by the patient based upon what the individual patient's needs are.

The fourth guiding principle should be that post-acute care providers must have the capacity to care for the needs of the patients that they are admitting. All post acute providers are not created equal and all patients' needs are not created equal. This is not a situation of one-size-fits-all when you talk about the post-acute care patient. It is a situation whereby the patient, depending upon what their individual needs are, should go to the level of care that can meet those needs. In the LTCH situation, RNs are at a higher ratio per patient because of the potential instability of the patient's medical condition than it currently is in a SNF situation. So, we firmly believe that there are different levels of care, that those levels of care can be defined, that the common patient assessment that could be developed would assist us in making that definition of what patient should go to the specific location. We do not believe that these levels of care are interchangeable. Thank you for allowing me to speak with you today. I would request that if you have not been to these different levels of care, there can be visits made to them, so that you can see on a first-hand basis what the differences in the patients are that are cared for at each of these levels, and what should be done to differentiate those specific levels of care. Thank you.

[The prepared statement of Ms. Rice follows:]

**Statement of Pat Rice, BSN, MSN, President/Chief Operating Officer,  
Select Medical Corporation, Mechanicsville, Pennsylvania**

*Representing*

**The Acute Long Term Hospital Association (ALTHA)**

Madam Chair, Members of the Committee:

Thank you for convening this hearing on post-acute care and for involving providers in these discussions. By way of background, I have served as a registered nurse and healthcare administrator for the past 37 years in a variety of settings including seven years at a university medical center, twenty years in inpatient rehabilitation, two years in hospital based skilled nursing and nine years in long term care hospitals. Currently, I am the President/Chief Operating Officer of Select Medical Corporation, operator of 99 long term care hospitals (LTCH), in 26 states and Kessler Rehabilitation Institute in New Jersey that is recognized as a premier rehabilitation hospital. U.S. News and World Report ranks Kessler the leading rehabilitation hospital in the East—and 4<sup>th</sup> best nationwide—marking the 13<sup>th</sup> consecutive year that Kessler has been named to this prestigious list.

I am also a Board member of the Acute Long Term Hospital Association (ALTHA). ALTHA represents over 300 LTC hospitals across the United States, constituting over two-thirds of LTC hospitals nationwide. ALTHA's member hospitals provide care to severely ill, medically complex patients with multiple comorbidities who require hospitalization for extended periods of time. Both Select Medical and Kindred Healthcare, another leading LTCH provider who also is the third largest operator of skilled nursing centers, are ALTHA members. ALTHA represents the vast majority of the LTCH industry.

**Introduction**

I commend the Committee for convening a hearing to discuss the critical role that post-acute providers play in meeting the needs of an important patient population. To be sure, there is a continuum of post-acute care that can create confusion among policymakers, payers and patients about which setting is most appropriate for patients with certain medical conditions. The purpose of my testimony today—as a nurse and operator of LTCHs and rehabilitation hospitals—is to assist the Committee in understanding the similarities and differences between the settings so that policy decisions can be made to achieve the goals of fiscal responsibility, patient access to care, and quality care.

In general, I believe the Committees deliberations should be guided by four overriding principles.

First, each provider in the post-acute sector plays a critical and distinct role in meeting the needs of the post-acute patient population. Policy should seek clearer definitions of those distinct roles but should recognize that a certain amount of overlap is inevitable and necessary to ensure continuity of patient care across settings.

Second, both ALTHA and Select support the Committee's efforts to explore and evaluate development of a comprehensive post-acute assessment tool. Development of such an instrument is an important prerequisite to integrating care, and possibly payment, across the post-acute setting. I caution the Committee, however, that development of an common instrument is a very complicated and important task. As described more fully in my testimony, the range, depth, and content of clinical information necessary to evaluate and treat LTCH patients is more comprehensive than is captured in the assessment instruments used by other post-acute providers. Accordingly, policy makers should proceed carefully in developing a common instrument and ensure active participation by clinicians involved in treating patients across the post-acute continuum.

Third, we support the principle that patients should be cared and paid for in the appropriate setting. MedPAC's recommendations and CMS's current research on revised certification criteria for LTCHs are designed to achieve this goal. While determination of appropriate setting is a complicated decision requiring extensive input from treating physicians in consultation with patients, we agree with the premise of MedPAC's recommendation that the decision should be made based primarily on patients' clinical characteristics and needs. Patients who can be safely and effectively cared for in SNFs should not be treated and paid for in LTCHs or IRFs. Conversely, severely ill, medically complex patients with multiple co-morbidities should have access to the intensive interventions only available in LTCHs. Again, from a clinical perspective, these determinations are not always clear. Policy should allow for some flexibility so that clinical judgment can be effectively exercised in the best interests of patients.

Fourth, as noted by MedPAC, policy should also require not only that patients be placed in the appropriate setting, but that providers in the post-acute sector have the capacity to meet the needs of the patients. As summarized below, staffing levels, staff skill mix, availability of diagnostic tests, sophistication of technology and intensity of service vary significantly across post-acute settings. While tempting for policy to encourage patients to be placed in the least intensive and least costly setting, this decision 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.

#### **Differences in Post Acute Levels of Care**

In the past 20 years, health care provided after the general acute hospitalization has become known as post acute services or the post acute care continuum. Included as post acute are long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF)—whether rehab unit or freestanding rehabilitation hospitals, skilled nursing facilities (SNF), hospices and home health. Although they tend to be categorized together, each setting is unique and there should be unique definitions of each that support the clinical care they are organized to deliver. They have few similarities and many differences. Similarities between post acute settings include providing for the health care needs of patients and doing so through medical personnel such as physicians, nurses and therapists. Each is regulated by state and federal authorities, and each is paid by CMS at a different rate for Medicare patients if the service is medically necessary and admission and continued stay criteria are met.

Differences between each of these levels of care include:

- 1) Reason for patient admission
- 2) Severity and acuity of illness
- 3) Risk of mortality
- 4) Intensity of monitoring services
- 5) Type and availability of services
- 6) Knowledge, specialization, amount of staff

#### **Reason for Admission**

The reason for admission for each level of care is:

**LTCH:** Medical observation and intervention for complex multiple medical conditions.

**IRF:** Comprehensive rehabilitation requiring rehabilitation physicians, nurses, therapists.

**SNF:** Restorative, requiring skilled nursing and/or skilled therapy.

**HH:** Skilled or unskilled care managed safely in home environment when patient/primary care giver demonstrates ability to manage care at home.

Each of these locations has the potential to care for the patient with a specific diagnosis(es). The placement decision should be based upon: patient needs, patient acuity, complexity of multiple conditions, stability, intensity of monitoring/observation required, knowledge and intensity of services required, staff expertise and knowledge, staff time required, and availability of technology and equipment.

For example, the patient who has experienced a stroke has the potential of being admitted to an LTCH, IRF, SNF or returning home with home health. The potentially unstable medically complex stroke patient who has multiple co-morbidities such as unstable diabetes, renal failure with dialysis, and/or respiratory insufficiency requiring respiratory therapy, will require multiple physicians' specialists, frequent laboratory tests, dialysis, nutritional support and acute frequent nursing observation and interventions would most appropriately be admitted to an LTCH.

The stroke patient with functional impairments in eating, dressing, bathing who is aphasic and has progressed to sitting, is medically stable, and can participate in a minimum of three hours of therapy a day, would most appropriately be admitted to an IRF where the patient would receive a comprehensive rehabilitation program that is medically directed. The patient would have a goal directed rehab treatment plan that is aggressive, rapidly responsive to change in the patient status, and delivered by the highly trained, experienced and licensed rehab team.

The stroke patient with functional impairments who is medically stable, but whose endurance is insufficient to participate in an active three hour a day program, or who has cognitive impairment that prevents learning would most appropriately be admitted to a SNF if she/he cannot be cared for safely at home with home health care.

## **LTCH Characteristics**

### ***Severity and Acuity of Illness; Complexity of Care***

Patients with medically complex conditions that are severely ill tend to utilize more staff time and clinical resources/interventions and be more medically unstable. In the post acute continuum, these patients are typically treated in LTCHs. These patients have multiple co-morbidities and many of these are being actively treated along with the primary diagnosis. LTCH care requires frequent, often daily physician assessment and intervention due to the high risk nature of the patients and multiple medical conditions that exist and have potential for rapid or unpredictable deterioration. Overall, severity of illness is significantly higher in LTCH than in other post acute settings.

### ***Risk of Mortality***

The risk of mortality is increased when the severity of illness is greater. The LTCH patient typically has multiple medically complex conditions, and the acuity of illness is high. When risk of mortality is higher, the need for intensity of monitoring services is greater.

### ***Intensity of Monitoring Services***

Intensity is established by a list of treatments, medications, interventions and therapy required by the patient based on the patient's needs and condition. When the patient's condition requires more frequent monitoring, intervention procedures, invasive treatment, intravenous medication and/or nutrition, the level of care required is of greater intensity and LTCH care is indicated.

### ***Types and Availability of Services***

The need for the availability of on-site services increases with the acuity and complexity of the patient's condition. Continuous cardiac monitoring, on-site pharmacy, diagnostic services, dialysis, intensive care or high observation units, emergency rescue services, i.e., code team are common services in LTCHs. Patients in IRF's and SNF's tend to be more stable, so available services on-site vary based on patient programs.

### ***Knowledge, Specialization, Amount of Staff***

The knowledge, specialization and amount of staff vary greatly in the different post acute levels of care. The medical staff in the LTCH is comprised of multiple specialists including pulmonologists; cardiologists; gastroenterologists; general, plastic and vascular surgeons; infectious disease and internists. These physicians see patients daily and consult routinely at the LTCH. The medical staff at the inpatient rehabilitation facility is also an organized staff model. The attending physician is typically the physiatrist. Consultants may see the patient at the hospital or in his or her office. The SNF typically does not have an organized medical staff. The attending physician may be the patient's family physician or a physician contracted with the nursing home to see patients. Consultants, when required, see the patients in his or her office.

The amount of nursing hours required by the patients, the ratio of RNs to other nursing staff, and the clinical expertise required is different in each setting. LTCHs require acute care nurses with emphasis on monitoring and managing potential and actual acute events with a higher number of nursing hours per patient day and a higher ratio of RNs. Advanced cardiac life support is paramount. Inpatient rehabilitation requires nurses with rehabilitation training with emphasis on mobility, cognitive and elimination, etc.

Rehabilitation therapists at inpatient rehabilitation facilities specialize in neurological treatment, spinal cord injury and traumatic brain injury. The level of specialization they need in rehab is not required in the LTCH or SNF.

Respiratory therapists in LTCHs utilize ventilator weaning protocols jointly developed with the pulmonologist to facilitate weaning. This level of expertise may not be required in a SNF with chronic ventilator management or in inpatient rehabilitation.

### ***Assessment Tool***

Developing a common assessment tool for post acute providers is an important but difficult task. Inpatient rehabilitation utilizes Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI) as their assessment tool. SNFs utilize Minimum Data Set—Resident Assessment Instrument (MDS-RAI), home health utilizes OASIS. These tools are specific to that level of care and not usable for the other or LTCHs. The current tools, (MDS-RAI, OASIS, IRF-PAI), are not sufficiently comprehensive to capture the severity of illness/acuity, the intensity of the services and

the complexity of the needs of the medically complex patient with multiple comorbidities requiring multiple interventions. The focus of these tools is the level of disability and the amount of help a person needs from others to perform basic activities of daily living. If one tool is to be created, clinicians from each of the post acute levels of care must be involved. Adequate trials of the tool must be completed before implementation. At the individual hospital level, when IRF-PAI was implemented, a new position of PPS coordinator was created and with MDS-RAI a MDS coordinator was created to ensure compliance and timely completion. Both positions are typically filled by registered nurses in a time of nursing shortages taking more nurses from the bedside and increasing cost to comply.

Key elements of a patient assessment tool that would adequately assess LTCH patients would include:

Indicators of severity of illness and intensity of services, such as

- Emergency management
- Medical complexity of care
- Infectious disease monitoring and management
- Intravenous interventions including medication and/or nutritional support through TPN
- Blood and blood products
- Medication titration
- Respiratory interventions, respiratory therapist time  
frequent suctioning  
brochoscopy  
tracheostomy care
- Potential for instability
- Lab monitoring
- Intensity of observations required in rapidly changing medical condition
- Hemodynamic monitoring
- Cardiac monitoring
- Frequent physician specialty consults
- Radiology diagnostic procedures
- Special procedures
- CT scans, MRI, EKG

### **Summary**

Again, on behalf of Select Medical and ALTHA, I commend the Committee for convening hearings on this important topic and soliciting the input of providers across the post-acute continuum. We urge the Committee to use as a guide the four principles summarized at the beginning of my testimony. ALTHA and Select Medical stand ready to assist the Committee in any way we can. Specifically, we urge Committee members and staff to visit LTCHs, IRFs and other post-acute providers to learn more about the fundamental differences in patients served in these settings and the capacity of different provider types to meet patient needs.

### **POST ACUTE LEVELS OF CARE**

	<b>LTCH</b>	<b>Rehabilitation</b>	<b>SNF</b>
<b>Reason for Admission</b>	Medical and Respiratory Needs	Comprehensive rehabilitation requiring therapy for functional impairments	Restorative requiring skilled nursing and/or skilled therapy
<b>Licensure/Registration (State)</b>	Acute	Acute or Rehabilitation	SNF
<b>Provider Number</b>	LTCH	Rehabilitation	SNF
<b>Medicare Classification</b>	Excluded Hospitals CMS 412.23	Excluded Hospitals CMS 412.23	SNF

**POST ACUTE LEVELS OF CARE—Continued**

	<b>LTCH</b>	<b>Rehabilitation</b>	<b>SNF</b>
<b>CMS Exclusion Criteria</b>	25-day Length of Stay	<ul style="list-style-type: none"> <li>• 75% of admissions within 13 diagnoses</li> <li>• Pre-admission screening</li> <li>• Team Conference</li> <li>• Medical Director Full-time Experienced/trained in rehab</li> </ul>	—
<b>Medicare Payment Basis</b>	LTCH-PPS	Rehab IRF-PAI Case Mix Groups <ul style="list-style-type: none"> <li>• Rehab Impairment Category (RIC)</li> <li>FIM</li> <li>Age</li> <li>• Comorbidities</li> <li>4 Tiers</li> </ul>	MDS-RAI RUGS
<b>Admission/Continued Stay Criteria</b>	Interqual or Mass Pro (Designated by QIO)	<ul style="list-style-type: none"> <li>• Functional deficit due to acute condition</li> <li>• Intensive, multi-disciplinary rehab</li> <li>• 24-hour availability MD Rehab Nurse</li> <li>• Able to tolerate 3 hours of therapy a day, 5 days a week</li> <li>• 2 disciplines required (PT, OT, Speech)</li> </ul>	Requires either skilled nursing or skilled therapy daily
<b>Severity of Illness</b>	Actual/Potential Instability	Stable	Stable
<b>Intensity of Interventions/Services</b>	High	Medium	Low
<b>Physician Assessment/Intervention</b>	<ul style="list-style-type: none"> <li>• Daily or more frequent</li> <li>• Multiple Physician Specialists</li> <li>• Pulmonologist available 24 hours</li> </ul>	<ul style="list-style-type: none"> <li>• 3x week to daily</li> <li>• Physiatrist</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly by regulation</li> <li>• MD/PA/NP</li> </ul>
<b>Nursing</b>	Acute Care Nurse 8.5h-12h PPD High RN ratio	Rehab Nursing 6.2h-6.5h PPD	Skilled Nursing at least daily 3-4h Low RN ratio
<b>Respiratory</b>	Active weaning management 24h/7d	As needed	—
<b>Pharmacy Services</b>	On-site	On-site	Delivered from off-site
<b>Diagnostic Services</b>	On-site	Varies	Off-site

**POST ACUTE LEVELS OF CARE—Continued**

	<b>LTCH</b>	<b>Rehabilitation</b>	<b>SNF</b>
<b>Rehabilitation Therapies (PT, OT, Speech)</b>	Varies based on patient needs Averages—1h/day	3 hours/day	1 hour/day
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Continuous cardiac monitoring</li> <li>• Acute intubation</li> <li>• Ventilator weaning</li> <li>• Mechanical ventilation</li> <li>• Comprehensive Medical Assessment/ Consultations</li> <li>• IV Medications/ TPN</li> <li>• Renal Dialysis</li> <li>• Wound Assessment/ Management including Enterstomal Therapist</li> </ul>	<ul style="list-style-type: none"> <li>• Rehab Therapies</li> <li>• Psychology</li> <li>• Cognitive Therapy</li> <li>• Urological Management</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled Nursing</li> <li>• Skilled Therapy</li> </ul>
<b>Assessment Tools</b>	No standardized assessment required by regulation	IRF-PAI	MDS-RAI
<b>LOS</b>	27	13	Approximately 40

Chairman JOHNSON. Thank you very much, Ms. Rice. Ms. Edelman.

**STATEMENT OF TOBY S. EDELMAN, SENIOR POLICY ATTORNEY, CENTER FOR MEDICARE ADVOCACY, INC.**

Ms. EDELMAN. Madam Chair and Members of the Committee, thank you for the invitation to testify today. My name is Toby Edelman; I am a Senior Policy Attorney with the Center for Medicare Advocacy, a private nonprofit organization that provides education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain necessary health care. Since 1977, I have represented and worked on behalf of nursing home residents. Most recently, I was a Member of the technical advisory panel that made recommendations to CMS about refinements to the Medicare reimbursement system for SNFs. The idea of using a uniform assessment instrument for post-acute care has been discussed for many years. A single comprehensive instrument might produce benefits of assuring appropriate care and improved care outcomes for beneficiaries; however, another key purpose of uniform assessment instrument is saving public money. It appears to make little sense to pay vastly different amounts for the same services based solely on the setting of care. While this point has validity, we need to keep in mind the unintended consequences of similar cost containment efforts in the past. Cost shifted from one

setting to another: uniform rates gave windfalls to some providers, eliminated other providers, and did not improve care for beneficiaries, and beneficiaries and providers each lost the opportunity to make choices about the site of health care. I would like to discuss these, each very briefly.

First, cost-shifting: 20 years ago, Congress enacted PPS for acute care hospitals. Research on the treatment of beneficiaries with hip fractures found enormous changes following implementation of the new reimbursement system. One study found that before PPS, patients received rehabilitation in the hospital and generally went home either directly or following a short stay in a SNF. After PPS, hospital lengths of stay declined from 22 days to 13 days in this study, and the percentage of residents discharged to SNFs increased from 38 percent to 60 percent. Nothing surprising here. The expectation was that patients would get the same rehabilitation services in SNFs that they had received in acute care hospitals, but at lower cost. This did not prove true. Researchers found that, for various reasons—and these are their words—“Rehabilitation therapy within the nursing homes was less effective than inpatient therapy before PPS.” Instead of getting therapy and returning home, patients were more likely to be in the nursing home a full year after their hip fracture. There was a 200-percent increase in the rate of nursing home residence 1 year after hospitalization after PPS. Not only were the care outcomes worse for beneficiaries with hip fractures, but expected cost savings also did not materialize as costs moved elsewhere. After PPS, although people with hip fractures spent less time in the hospital, they then became Medicare patients in SNFs, and then, as the researchers found, long-term care residents in nursing homes. So, the savings in Medicare acute care costs were accompanied by increases in post acute costs for both Medicare and Medicaid. Care was worse; costs shifted. I promised my friend, Mary Ousley, that I would say that the study does not reflect care in nursing homes today, which we would agree is better following implementation of the nursing home reform law.

Second point: Recent experience in nursing home reimbursement following enactment of the PPS in 1997 illustrates some consequences of establishing uniform rates. The PPS system for SNFs eliminated the longstanding payment differential between reimbursement rates for free-standing and hospital-based SNFs. All SNFs now receive the same rates, based on assessed needs of their residents. The CMS used both sets of rates when it computed the new uniform rates, however, and so hospital-based SNFs wound up with lower rates and free-standing SNFs got a windfall. The GAO reports that hospital-based facilities had extremely negative margins. Twenty-6 percent of the units closed between 1998 and 2000. On the other hand, free-standing facilities increased their Medicare margins from 8.4 percent in 1999 to 18.9 percent in 2000. Paying uniform rates across SNF settings did not assure necessary care was provided to beneficiaries. The GAO reported that SNFs changed their care practices in response to the PPS system so that the majority of residents, in fact, received less therapy than before.

The last point is about choices for beneficiaries. Generally, Federal law guarantees beneficiaries the right to choose among post

acute providers that are certified to provide them with care and that agree to serve them. Use of the uniform instrument raises some questions. Would such an instrument eliminate beneficiary choice and automatically limit beneficiaries to the least expensive care setting? Some years ago, beneficiaries in a western State were denied the right to choose a hospital-based SNF when a lower cost, free-standing SNF was available. Beneficiaries objected when they were told they would have to move great distances from their families. Post-acute care for many people becomes a permanent placement. While people may choose short-term care in distant locations, they usually want to be near families and friends if a placement turns into the rest of their lives. We need to be concerned if a uniform assessment instrument precludes beneficiary choice among appropriate providers. The evidence is in conflict whether the different post-acute care settings actually serve the same or different populations, and whether they provide the same or different services or intensities of services. We do know that people become more different from each other as they age; and the combination of various chronic and acute conditions, mental functioning, and social factors may make people with similar post acute conditions very different from each other in significant ways that may justify different post acute settings.

Finally, I think assuring accurate and comprehensive assessments so that Medicare beneficiaries get the care and services they need in the appropriate setting of their choice is an important public goal of uniform assessments and could certainly be an improvement over today's system. If paying the lowest rate possible is the primary goal of uniform assessments, beneficiaries may not be well served, and it may create a false sense of savings if costs are simply shifted elsewhere. I don't have simple answers to these concerns, and I am not suggesting that change isn't needed, but I am encouraging you to proceed with caution in this highly complex area of post-acute care. Thank you.

[The prepared statement of Ms. Edelman follows:]

**Statement of Toby S. Edelman, Senior Policy Attorney, Center For Medicare Advocacy, Inc.**

Madam Chairwoman and Members of the Committee:

The idea of using a uniform assessment instrument for post-acute care has been discussed for many years.<sup>1</sup> As Congress has recognized, there are many potential benefits from using a single instrument. A single, comprehensive instrument might lead to more uniformity, more accuracy, and less confusion if it captured all relevant information about patients that health care providers needed in order to assure appropriate post-acute care for Medicare beneficiaries. Improved care outcomes for Medicare beneficiaries could result.

In addition to planning care for beneficiaries, however, another key purpose of a uniform assessment instrument is saving public money. It appears to make little sense to pay vastly different amounts for the same services, based solely on the setting of care. While this point has validity, we need to remember the unintended consequences of similar cost-containment efforts in the past. Costs shifted from one setting to another; uniform rates gave windfalls to some providers, eliminated other

<sup>1</sup>Joan L. Buchanan, Ph.D., et al, "An Assessment Tool Translation Study," *Health Care Financing Review* 24(3): 45-60 (Spring 2003) (describing benefits from comparable measures across settings, but difficulties in developing a single assessment tool for long-term care); MedPAC, *Report to Congress: Medicare Payment Policy* 93 (March 2001) (noting 1999 and 2000 MedPAC recommendations to develop a common core set of assessment data elements for post-acute care).

providers, and did not improve care for beneficiaries; and beneficiaries and providers lost the opportunity to make choices about health care.

*Cost-shifting.* Twenty years ago, Congress enacted a prospective payment system for acute care hospitals. One explicit purpose was reducing hospital costs. A considerable amount of research found, as expected, that hospital lengths of stay were reduced following the introduction of PPS. There is certainly a benefit to that result, in and of itself, both for public payment systems and for beneficiaries. But some less predictable and less beneficial results also occurred.

Research on the treatment of beneficiaries with hip fractures found enormous changes in care settings and costs following the implementation of PPS. One study found that before PPS, patients received rehabilitation in the hospital and generally went home, either directly from the hospital or following a short stay in a SNF. After PPS, hospital lengths of stay declined from 22 days to 13 days and the percentage of residents discharged to SNFs increased from 38% to 60%. The expectation was that patients could get the same rehabilitation services in SNFs that they had received in acute care hospitals, but at lower cost. This did not prove true. After PPS, the researchers found that, for various reasons, “rehabilitation therapy within the nursing homes was less effective than inpatient therapy before PPS.” The outcomes for patients with hip fracture were worse following PPS. Instead of getting therapy and returning home, patients were more likely to be in the nursing home a full year after their hip fracture; a 200% increase in the rate of nursing home residence was reported by the study after PPS was implemented.<sup>2</sup> The researchers called this finding “alarming” and their most important finding. Services were not the same in the different settings.

Not only were care outcomes worse for beneficiaries with hip fractures following PPS, but expected cost savings also did not materialize as costs moved elsewhere. After PPS, people with hip fractures spent less time in the hospital, but these patients then became Medicare patients in SNFs and then, frequently, as the researchers found, long-term residents of nursing homes. Medicare payments to SNFs increased in the years following implementation of PPS for hospitals.<sup>3</sup> And patients who would have gone home from the hospital now found themselves living in nursing facilities on a long-term basis, generally, as Medicaid beneficiaries. Savings in Medicare acute care hospital costs were accompanied by increases in Medicare and Medicaid post-acute costs. Costs shifted from one setting to another, with worse care outcomes for beneficiaries. Lessons learned from this experience are that lower-cost settings do not necessarily provide comparable services and that new health care costs may emerge in other settings.

*The consequences of uniform rates:* Recent experience in nursing home reimbursement following enactment of a prospective payment system in 1997 illustrates the consequences of establishing uniform rates. The PPS system for skilled nursing facilities eliminated the long-standing payment differential between Medicare reimbursement rates for free-standing and hospital-based SNFs. All SNFs now receive the same rates, based on the assessed needs of their residents. In developing these rates, the Centers for Medicare & Medicaid Services used both free-standing and hospital-based rates. When the rates were combined, hospital-based SNFs wound up with lower rates and free-standing SNFs got higher rates (i.e., the financial benefit of the higher rates that hospital-based SNFs had received). As a consequence of these changes, the Government Accountability Office has repeatedly found that free-standing facilities have increased their Medicare margins—from 8.4% in 1999 to 18.9% in 2000—and hospital-based facilities have had extremely negative margins,<sup>4</sup> with 26% of the units closing between 1998 and 2000.<sup>5</sup>

Paying uniform rates across SNF settings did not assure that necessary care was provided to beneficiaries. In a series of reports, the GAO found that SNFs changed their care practices in response to the PPS system so that residents received *less*

<sup>2</sup>John F. Fitzgerald, M.D., et al, “The Care of Elderly Patients with Hip Fracture,” *New England Journal of Medicine* 319(21):1392–1397 (Nov. 24, 1988).

<sup>3</sup>MedPAC reported that Medicare spending in SNFs increased from \$3.6 billion in 1992 to \$13.5 billion in 2003. MedPAC, *A Data Book: Healthcare Spending and the Medicare Program* 142, Chart 9–2 (June 2004). Other factors also contributed to the growth in SNF care during this period, including new SNF coverage guidelines issued in 1988, enactment of the Medicare Catastrophic Coverage Act of 1988 (which revised rules for SNF coverage), and Medicare’s use of cost-based reimbursement prior to 1998. “A Review of Issues in the Development and Implementation of the Skilled Nursing Facility Prospective Payment System” 2 (May 2004).

<sup>4</sup>GAO, *Medicare Payments Exceed Costs for Most but Not All Facilities*, GAO–03–183 (Dec. 2002).

<sup>5</sup>“A Review of Issues in the Development and Implementation of the Skilled Nursing Facility Prospective Payment System” 29 (May 2004).

therapy than before.<sup>6</sup> And SNFs failed to increase nurse staffing, despite a statutorily-mandated increase in the nursing component of the Medicare rates.<sup>7</sup> These reports demonstrate that reimbursement systems alone are not sufficient to assure that facilities provided appropriate care and services to Medicare beneficiaries. A strong regulatory system, with incentives that are consistent with, and complemented by the reimbursement system, is necessary.

*Choice for beneficiaries:* Generally, federal law guarantees beneficiaries the right to choose among post-acute providers that are certified to provide them with care. As long as the provider agrees to serve the beneficiary, the beneficiary can choose among providers.

As we think about a uniform assessment instrument, questions arise. Would such an instrument restrict beneficiary choice and limit beneficiaries to the least expensive care setting, regardless of beneficiary and provider choice to the contrary? Some years ago, beneficiaries in a western state were denied the right to choose a hospital-based SNF when a lower-cost free-standing SNF was available. Some beneficiaries objected when they were told they would have to move great distances from their families to a free-standing facility. Post-acute care, for many people, becomes a permanent placement. While people may choose *short-term* care in distant locations, they usually want to be near families and friends if a placement turns into the rest of their lives. An assessment instrument should not be used to limit beneficiary choice among appropriate post-acute providers.

Finally, do various post-acute settings *in fact* serve the same populations and provide identical services? The evidence is in conflict.

Some evidence indicates a clear overlap in the populations served by different post-acute care settings and in the services these settings provide. The increasing acuity of SNF residents is demonstrated by the proposed Medicare reimbursement rules for SNFs, published last month, which modify the 44 assessment categories and add nine new high-cost categories to reflect residents who are medically complex and also need rehabilitation.<sup>8</sup> On the other hand, some studies indicate that post-acute providers may serve different people or provide different intensities of services, or both.<sup>9</sup>

Geriatricians tell us that people become more different from each other as they age. The combination of various chronic and acute conditions and health care needs may make people with similar post-acute conditions different from each other in significant ways that justify different post-acute settings. While government payers do not want to pay for more expensive services when less expensive services would work equally well, older people may have different needs, or may suddenly and unexpectedly develop new needs, and require different settings as a result.

Assuring accurate and comprehensive assessments so that Medicare beneficiaries get the care and services they need in the appropriate setting of their choice is an important public goal of uniform assessments and could be an improvement over today's system. However, 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.

Thank you.

The Center for Medicare Advocacy is a private, non-profit organization founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and healthcare rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Toby S. Edelman is a Senior Policy Attorney with the Center for Medicare Advocacy in the Washington, DC office. Since 1977, she has represented and worked on behalf of nursing home residents. She was a member of the Medicare SNF Technical Advisory Panel that considered refinements to the Medicare SNF reimbursement system (2004).

<sup>6</sup> GAO, *Skilled Nursing Facilities; Providers Have Responded to Medicare Payment System By Changing Practices*, GAO-02-841 (Aug. 2002).

<sup>7</sup> GAO, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, GAO-03-176 (Nov. 2002).

<sup>8</sup> 70 Federal Register 29070 (May 19, 2005).

<sup>9</sup> MedPAC, *Report to Congress: Medicare Payment Policy* 91-92 (March 2001).

Chairman JOHNSON. Thank you. Thank you. It is interesting to hear the unintended consequences of past policy changes. There are two issues I want to plumb. First of all, on this issue of uniform assessment tool, it does seem to me from listening to the testimony of both the first panel and the second panel that there is some definable body of information that could be used to make that as a common base; though clearly, there is a need for additional assessment in each setting. It does seem to me that if you did that, you would end up altering the OASIS and MDS and everything else. If you have something that takes the first piece of it and then you add on, depending on the institution's focus, you would change all tools. Now, is that where you think we are heading, those of you who are much closer to this than I am? Dr. DeJong.

Dr. DEJONG. Yes, I think so. I think that one of the difficulties we are going to have is getting consensus on the core elements. Each post acute sector is highly vested in its particular instrument and its approach. All these instruments were developed over long periods of time through consensus building and research. The silos that are represented in these institutions, and these post acute industries, are not just the facilities themselves; it goes much deeper. With the skilled-nursing industry, for example, there are people who are trained in long-term care who have had their entire professional careers in the area of long-term care, and that has spilled over into skilled nursing. You have got people in the rehabilitation community who have come through their particular traditions and whatnot. Each of these silos has certain cultural and intellectual traditions that are reflected in the instrument that each uses. To obtain consensus across the different sectors and different silos, I think is going to be quite a challenge. I think we are going to need to do that. I think one option is to allow people to retain certain elements of what they currently have, but make it auxiliary to the core instrument.

Chairman JOHNSON. Ms. Ousley.

Ms. OUSLEY. Having the assessment instrument, actually I think that has been in place the longest in skilled nursing. I firmly believe that there is a core set of data elements that can go across all settings. Now, for MDS, CMS is in the process now of looking at an update, which is overdue. To me, it seems that the time is right to be able to look at what is the core set of data elements that can go across the settings. The three things that we can't lose sight of are that, whatever this instrument looks like, it must be able to define the care, link it to payment, and we have to be able to define outcome measures. I am not so wedded to MDS that I don't see the need for change. We have, I think, the best database in the Nation of MDS-derived quality indicators over the years that we have used it, and would love to be able to see that continue and, again, go across all post acute settings. I think it is doable.

Ms. RAPHAEL. I was struck when MedPAC took a look at this, and, in fact, we all are looking at the same things, for example, mobility. When you looked, one person was saying, "Did you walk 20 feet?" Another one was looking, "Did you walk 100 feet?" "Did you walk unassisted?" So, I think we are all looking at the same things to some degree; it is just how we are defining and when we are

measuring. I think that there could be consensus here on what we think is important in trying to make these determinations.

Chairman JOHNSON. Then just to focus on the nursing home for a moment. I recently visited a nursing home that is part of the Evercare program, and they don't use MDS, they just have a case manager and outcomes—just outcomes focused. The person is in the nursing home, working with a nursing home staff, but it is an Evercare patient. So, I was interested that they could just not do the MDS forum. So, I do think we need to think clearly about this base data. Dr. Votto, you mentioned in your testimony that you thought that from the trial program—and I want to come to you, Ms. Rice, to see if you are familiar with this research that they are doing, because that seems very promising to me. It is the only tangible, concrete, fairly comprehensive effort being made right now, as far as I can tell.

Dr. VOTTO. Right. The point I would like to make is that I think we can have a basic patient assessment tool. I think one of the things about the silo concept is that in many of the programs that we have in the LTCH industry, you do need a critical mass of patients. You can't just have a weaning program and have three patients a year or ten patients a year. You have to have a program. A spinal cord program is very similar, brain injury is very similar. If you want to have a comprehensive program which is multidisciplinary, you do have to have a core or critical mass, I believe. If you had a patient assessment tool which would separate out those small groups of patients, then maybe geographically you don't have many of these programs. I think that that has to be—that point has to be made.

Interestingly, in the study that we did with the ventilator patients, we had thought that the patients that ended up on prolonged mechanical ventilation would be the very sick; coming out of nursing homes, just going into a hospital Intensive Care Unit (ICU) and not getting better. It turns out, 86.5 percent of those patients were independently living before they ever ended up on prolonged mechanical ventilation, and 82 percent of them were very functional out in the community before they ended up on prolonged mechanical ventilation. So, we are not talking about a patient population that is at the end of life and at the end of the rope, and they come in and we are doing all these things to them; they were actually very functional, most of them. So, that kind of data is important to have, I think.

We also found that 42 percent of them had bed sores when they came to our hospitals. Also, some very interesting data was that the Acute Physiology and Chronic Health Evaluation (APACHE) scores—which is an acute physiology score, an acuity score which measures your likelihood of dying—when compared to ICUs in multiple patients, thousands of which were in one study, the APACHE scores of patients going into the ICUs was 41. The higher, the worse it is, and the range is zero to 115. The scores in our study were 35, meaning that our patients that were coming into the LTCHs for weaning were just about as critically ill as the patients going to the ICU the first time. So, you do get very interesting information when you do study subpopulations.

Chairman JOHNSON. Interesting.

Ms. RICE. I am familiar with that study, and it is—the tool that will have to be developed to be usable by the LTCH industry, as well as post acute, is a tool that will have to look at complexity. Whereas most of the tools that have been developed thus far, IRF-PAI, MDS, they look at functional independence measure as it relates to Activities of Daily Living (ADL). The patients that we are seeing, we are more concerned about if they are going to survive the hospitalization, their risk of mortality because of the level of illness. Although it would be nice to know that, it is not the primary thing that we treat during the long-term acute care hospitalization. So, for admission, we use criteria currently in our hospitals and in most of the LTCHs, because most of the QIOs are now using it; we use InterQual criteria for admission and continued stay. That is more oriented toward the acute care, acute hospital, rather than toward the post-acute care arena, so that the two will have to be significantly different than the tools that are currently out there.

Chairman JOHNSON. Dr. Votto, do you have any comment on the InterQual criteria?

Dr. VOTTO. My biggest concern about the InterQual criteria are the mutual exclusivity that is inherent in them. In other words, if you qualify for an IRF, you don't qualify for an LTCH. If you qualify for an LTCH, you don't qualify for a SNF. If you qualify for an acute care hospital, you don't qualify for either of the other two. I am concerned about that as the payment following the criteria that InterQual has. That is one of the problems that I have with it. There are a few other things that I think are very rigid about their criteria, but I think that that is the major issue that I see with them. I don't think they really differentiate patients correctly.

Chairman JOHNSON. Interesting.

Dr. VOTTO. They don't follow the PPS, as far as I am concerned.

Chairman JOHNSON. Ms. Edelman.

Ms. EDELMAN. Yes. Thank you. I wanted to say one thing about the MDS that is used in Medicare SNFs, because the 1987 Nursing Home Reform Law (P.L. 100-175) made the same standards basically for Medicare SNFs and Medicaid Nursing Facilities. The assessment instrument that is used, the MDS, has a lot of information that is important for a long-term care stay, for somebody who will be living in an institution for a prolonged period of time. The part that is unique about the MDS, or one of the parts that is unique, is the section on customary routines. This section tries to understand who that person is, when the person likes to get up, go to bed, things that might not be as relevant for other settings. I would not want to lose that part of the assessment process because it has been a very important part of nursing home reform and is really making care better for residents.

Chairman JOHNSON. Interesting. Mr. Lewis, would you like to inquire?

Mr. LEWIS. Thank you very much, Madam Chair. Madam Chair, I want to be very brief and apologize to you for being a little late, but a group of young students from Connecticut hijacked me, or maybe they tried to kidnap me, on the steps of the Capitol and I had to speak to them. So, I didn't think you would mind. Thank you very much. I want to thank each and every one of you for being

here. I know you have been so patient and it has been a long afternoon for you. I know you hadn't planned to be here so late. I have been trying to peruse each statement, and really appreciate all the wonderful information that you have provided, so I would be very, very brief. I just want to say, higher SNF reimbursement under Medicare appears to be cross-subsidizing Medicaid's lower rates. Medicaid isn't before our Committee. We deal with it indirectly and remain concerned about the potential cuts this year on behalf of the people we serve and with respect to how it could affect Medicare. Now, if Medicaid is on the table, with all due respect, you hope that Congress will find the big money. Are you concerned about Medicaid cuts this year? What might that mean to your patients and facility?

By the way, you are here, and while you are here this is an oversight hearing, and maybe I can just—this may be sort of off message and maybe not complete, Madam Chair, in compliance with the hearing—but I want to ask you, do you have any concern about how the new Medicare prescription drug program will impact you, your patient, your facilities? Anyone. Each one can say something.

Ms. OUSLEY. To your first question. Any potential cuts in skilled nursing today, be they from Medicare or from Medicaid, would be very difficult for us to deal with. We have—I think we do have a high acuity level of patients, and we are, of course, looking at individual States all across the Nation and hoping that Medicaid cuts will not hit us in such a way that will compromise our ability to provide that care. As we are learning on a daily basis now what the impact of the Medicare prescription drug benefit is going to be, I quite honestly have to tell you that even though we are very few months away from implementation, in our nursing facilities we are still trying to figure out exactly how we are going to manage that process, how we are going to make sure that the residents have the appropriate choice, the cost containment, if appropriate. All of those details are simply not available to us now today. I will tell you that there is a high level of apprehension in nursing facilities and by managers such as myself of being able to administer this in an appropriate way to meet the needs, the intent of the statute and meeting the needs of our residents.

Mr. LEWIS. Thank you.

Ms. RAPHEL. We see about 24,000 patients a day, and a number of them are dual-eligibles.

Mr. LEWIS. You say you see 24,000 patients a day?

Ms. RAPHEL. Right. A number of them are dual-eligibles.

Mr. LEWIS. For both Medicare?

Ms. RAPHAEL. They are both Medicare- and Medicaid-eligible. I would say that at this point we really don't know enough about how the implementation is going to evolve. We are working with a number of groups in our community to make sure that people are educated and informed and know how to go through the process, but it is not yet clear. Our greatest concerns are about those people who have depression or anxiety and who have finally been stabilized on medication regimes and who cannot afford any destabilization period, and trying to make sure that they don't miss a beat as we move to the new system.

Mr. LEWIS. Thank you.

Dr. DEJONG. I am concerned about the new prescription drug benefit because I think it is extraordinarily complicated and confusing with the various deductibles, the doughnut hole, and whatnot. I am trained in health policy, and I don't fully understand it, and I pity the beneficiary who is going to cope with it. The kinds of beneficiaries that are in the types of facilities represented here, are not necessarily people who have the wherewithal to fully understand the benefit and how it is going to affect their lives. I think a massive education process is needed, and I would suspect that no education will ever be adequate to the complexity of the benefit. I am deeply concerned that a lot of people are not going to understand the benefit and are not going to be able to use it appropriately.

Mr. LEWIS. Doctor, do you have any recommendations or suggestions that Members of this Committee or the Congress could take?

Dr. DEJONG. Well, I think it is inherent in the structure of the benefit itself. I don't know how you get around it. With the doughnut hole, the deductibles, and the record keeping that people are going to have to do to figure out whether or not they are over the deductible or in the doughnut hole, and when the full coverage starts kicking in upon reaching the "catastrophic" threshold. I don't have a solution. I don't think there is any amount of education that is going to help beneficiaries get through all that complexity.

Mr. LEWIS. Others?

Dr. VOTTO. I don't know that the drug bill will affect the inpatient, the LTCH, at this point. I am not sure of that. I do know that Medicaid cuts could be a major problem for us. About 60 percent of our revenue is from Medicaid, from the hospital standpoint, and about 80 percent at the nursing home. So, I think that Medicaid cuts are going to be a major problem for us. Any Medicaid cut would be a major problem. I hope that there is a—I don't know the transition for the drug program, but we hope that that will be a smooth transition, and that is all.

Mr. LEWIS. Thank you. Yes, ma'am.

Ms. RICE. As a hospital we are reimbursed under Medicare part A, so drugs are included as part of our overall PPS reimbursement system. So, on an inpatient hospital basis we really should not be affected by the drug bill essentially. As far as Medicaid is concerned, we do see relatively large number of Medicaid patients that require LTAC in patient care. Certainly cuts in the Medicaid program would adversely affect our ability to care for those patients.

Mr. LEWIS. Thank you. Yes, ma'am.

Ms. EDELMAN. Most nursing facilities in the country participate in both Medicare and Medicaid. Medicare is generally ten or twelve percent of facilities' reimbursement. Mostly facilities rely on Medicaid. That is the major payer, so, there are concerns if cuts are very steep. This could be very, very difficult. I think the Medicare Part D is a very complicated benefit for nursing home residents in particular. When residents come into an SNF as Medicare beneficiaries, they are covered by part A, and that includes drugs. Once Medicare ends, which is usually 20 days, 30 days—very few people get the full 100-day benefit—then they would need a Part D drug plan. They might have to change drugs right then. What CMS has

said is that the way to get a medically necessary drug that is not covered by the formulary of the plan that the person is in is to go through the exceptions process. That is going to be a very difficult and confusing process for people.

Many people in nursing homes are dually eligible—that is, they are eligible for both Medicare and Medicaid. Once Medicare coverage ends, they are then covered by Medicaid. What CMS is going to do is randomly assign people in the fall to a prescription drug plan to make sure that there is coverage for their prescription drugs once they are on Medicaid. When CMS does this random assignment, because it is random, it is not going to take into account what drugs the person needs. As a result, the person could be assigned to a Prescription Drug Plan (PDP) that has a formulary that does not include that person's drugs, or the PDP may not have the pharmacy that the nursing home uses. There can be tremendous complexities to make sure that people don't have gaps in coverage when January 1st comes. We have been meeting collectively with CMS and with the provider associations, with the pharmacists, various health care professionals, but it is complicated. Part D is not really ready to be implemented at this point.

Mr. LEWIS. I want to thank each of you for being here, and adding so much needed information as we wrestle with some of these tough and hard decisions. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. I thank my colleague, Mr. Lewis of Georgia. The Subcommittee will have a separate briefing on this. It is not surprising. You don't—you aren't informed about it, since we are almost seven months out from the program beginning. There is—the administration has a very logical and very direct and I think quite simple program planned. They are already communicating with the States. All the people who are in Medicare and dual-eligible will find it very easy, a much easier experience. Sometimes, by accident, you do something really brilliant. The discount plan proved to be really brilliant in the sense it gave us all a lot of experience with: how do you communicate; how do the different levels of government communicate; how does the private sector and the public sector communicate; how did the seniors understand? So, we come to this—this will challenge with a much greater body of experience. Now, the nursing homes have a unique problem, because they usually have their own pharmacy capability, and that has been a subject of discussion between the administration and the nursing home industry to try to make sure that that works smoothly—that they are discharged, and that that will work smoothly.

These problems were inevitable, but they—in my mind, the choice between seniors having a prescription drug coverage and having to solve problems is a no-brainer. So, I am interested in the heavily negative tone at the table. For me, I am just thrilled that so many seniors will have really good drug coverage. Now, I am very pleased that the administration also recently made very clear that the offerings for people with mental health problems and problems like that are going to be very broad. So, we shouldn't have these problems of an appeals process by people who are in multiple complex groups of drugs and would not be in a good position to appeal. Always when you put a new program in place—when an em-

ployer puts a new program in place if they have several thousand employees, there are always some rough spots. I believe we will be able to work out the problem with the nursing homes to everybody's satisfaction. It is moving along. One thing that is unique about this administration, having served under four Presidents of both parties, I can tell you that I have never, ever, served under an Administration that had the time, energy, and respect for the constituents and the providers that this administration does.

So, people do come in. They do talk, there is dialog. There is a lot of dialog between the Federal government and the State government about the dual-eligible population. On the experience of the discount program, we are going to be able to move that, I think, very easily and without a lot of concern by the seniors themselves. I think the nursing home problem will work out. The conversations between the employer sector and the government are going well, because that is a different, unique wrap-around issue, and you see many categories of seniors aren't affected by the structure of the program. The structure, with its period of personal responsibility—I prefer to call it personal responsibility as opposed to a doughnut hole because, frankly, my husband and I can afford \$3,500 if we need to, and my children can't. In the long run, that is why there is a personal effort thing. The personal effort is not at the beginning, because then people who couldn't afford \$3,000 off the bat get no program. So, we provide enough programs so that about 60 percent of seniors will have all of their drugs covered. Then there is a personal effort. Cut out from the personal effort people are all the Medicare/Medicaid. They don't have personal effort.

All the people in Connecticut's Program of All-Inclusive Care for the Elderly (PACE) or Pennsylvania's PACE program or the six or eight States that have subsidy programs—we saved Pennsylvania just for the discount card, someone was telling me on the floor today, \$90 million last year. They were able to up the income program of their PACE program because under the law the PACE contributions count toward the \$3,500. So, in Connecticut where our PACE program income is now approaching 200 percent of poverty income—maybe it is more than that, I have forgotten—you might know, John. We will be able to use our savings to attune that income level, because it has to be higher in the Northeast where the cost of living is higher. Mississippi wouldn't need as high a one. So, from this savings the States will be able to attune that State program level to the point where, people who can't afford the \$3,500 are never exposed to it. People on the integrated plans, advantage plan, can be protected from the \$3,500 till probably they will never need it. So, this is a flexible structure that provides, for \$400 billion, an absolutely extraordinarily good benefit. The idea of a benefit with no doughnut hole was \$1.3 billion, and that is to start.

So, we have to be realistic in today's world. We have got a good, solid program to implement any new benefit to seniors, and all of the circumstances they find themselves in is really difficult. I know for an absolute fact, because I circulate the senior citizen centers a lot, that I have seniors paying the most extraordinary amount of money for Medigap insurance. I am just shocked. I know they are going to have many lower-cost alternatives for more integrated care and for those with chronic illnesses, that will absolutely be a big

boon—and the integrated drug program into either integrated care or fee-for-service care. So, while I appreciate you don't know all that you need to know now, I hope you will remember that this is a giant step forward. There are so many middle-class seniors who can't afford Medigap insurance who are going to be able to afford \$37 a month, \$35 a month. They will be integrated plans that will probably have lower premiums than that—remember the old zero premium plan—they seem to be coming back. Some of those will include a very small payment premium for drugs, because with integrated care, you and I know, you can keep people out of hospital, you can keep money out of emergency rooms, and that money flows back to the patient. In the government, we keep people out of the hospital and it flows back to us.

So, there are some interesting, new and tremendously positive possibilities in bringing prescription drugs into Medicare. The biggest, most important, new possibility is this possibility of integrated comprehensive chronic disease management which will, in the end, flow right into the kind of basic assessment we are talking about. Because as people manage chronic illness, and when we get that electronic health record—it is one question I meant to ask them earlier—we really need to think as we move toward a basic assessment and a series of new assessment tools in a rather complicated area, we ought to try to coordinate this with the implementation of electronic capability, because we have got to have better electronic capability in health care for accuracy, for patient safety, for everybody's well-being. This will be much less complicated to implement if we think about it from the beginning and we structure it from the beginning with the electronic capability in mind.

So, quality is the real challenge in health care; in a health care sector that is developing new and remarkable treatments and diagnostic capabilities and care capabilities that were simply never imagined. So, we have to have the help of the electronic records. We have to have medications, we have to know people can get them. This is a first giant step toward that. I hope all of you at the table—because every one of you have the brains enough to be a font of information about this program—make it your business to not say oh, this is so complicated; make it your business to say, just tell me your zip code and I will tell you what is available.

Mr. LEWIS. Madam Chair.

Chairman JOHNSON. Yes.

Mr. LEWIS. I want to be sure that I heard you correctly. Did you suggest that we would hold a briefing on the Medicare—

Chairman JOHNSON. Oh, yes, we will.

Mr. LEWIS. Would we also consider holding an oversight hearing on the program?

Chairman JOHNSON. We will see the right time for that—certainly we need to do that. Whether we hold a public hearing at this time, we will decide. Certainly I want the Committee to see the rollout that the agency has now put in place. We hope to do that before the August recess; maybe before the July recess.

Mr. LEWIS. Thank you.

Chairman JOHNSON. Thank you all for participating. My heartfelt apologies for having this hearing dragged on so long, but it is

a big issue. Remember, your thoughts are welcome throughout the process, because this is going to be a challenging process. Thank you very much. The hearing is adjourned.

[Whereupon, at 5:35 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**Statement of Felice Loverso, Ph.D., American Medical Rehabilitation  
Providers Association**

The American Medical Rehabilitation Providers Association (AMRPA) is the leading national trade association representing over 450 freestanding rehabilitation hospitals, rehabilitation units of acute care general hospitals and numerous outpatient rehabilitation services providers. Our members serve over 450,000 patients per year, and most, if not all, of our members are Medicare providers. We appreciate the Subcommittee's focused attention on post-acute care services in Medicare. Rehabilitation hospitals and units are a crucial part of the spectrum of post-acute care providers, and we believe it is important to examine the issues surrounding this complex area of care.

An ongoing debate exists among policymakers, providers and various organizations about whether skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and possibly long term care hospitals (LTCHs) provide the same programs and activities with equivalent outcomes to patients needing medical rehabilitation services. Facilities should be compared both by their physical attributes, and the complete nature of the care and services they are organized to provide. Comparing facility performance solely by patient diagnoses or cost provides an extremely limited picture of the patients treated in these settings, the nature and value of the care they receive. One must look at additional patient information to truly appreciate the patients and their characteristics.

IRFs provide programs of care that utilize skilled rehabilitation services to Medicare patients at a pace, intensity, and sophistication that cannot be obtained in other health care settings. IRFs provide intense rehabilitation medicine and therapy to patients with 24-hour nursing and physician services. Patients receive a high-quality, coordinated program of care with the goal of achieving the maximum level of function possible and a rapid return to the community.

ARMPPA shares the Committee's interest in examining the complicated issues surrounding assessment tools and looking at other ways to address payment across post acute providers, and we appreciate the opportunity to present our recommendations to the Committee.

**75% Rule**

One overarching concern facing all post-acute care rehabilitation providers is the dramatic impact implementation of the 75 Percent Rule on patient access to rehabilitative care. The 75% Rule is unquestionably having a more severe impact on patients and providers than CMS or OMB originally estimated. The Medicare program originally estimated that implementation of the 75% Rule would reduce payments to IRFs by \$10 million in FY 2005 and \$30 million in FY 2006. However, the President's FY 2006 Budget revised these estimates to show a savings of \$50 million in FY 2005 and \$70 million in FY 2006. AMRPA's own data suggest that Medicare is likely to save *\$165 million dollars* in the first year alone. Clearly, CMS did not anticipate such a dramatic decline in patient services as a result of implementing this regulation.

Most alarming is the impact the rule is having on patients' access to treatment. Clear evidence now exists that IRF discharges have started to decline, and this change is orders of magnitude greater than CMS estimated. ERehabData®, AMRPA's data service, estimates that in the first year alone, over 39,000 patients will be refused admission to inpatient rehabilitation facilities in order for hospitals to maintain compliance with the new 75% Rule. For the first three quarters under the new 75% Rule, volume is down 5.8% from the comparable three quarters in 2003 and 2004, meaning that approximately 20,000 Medicare patients have been denied admission since July 1, 2004. By the fourth year of the 75% Rule, IRFs will be forced to turn away one out of every three patients in order to remain compliant. As noted in the GAO Report entitled "More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities," only 6 percent of IRFs will be able to meet the 75 percent threshold required at full implementation of the rule at the end of the transition period. Without any direction from Congress, the 75% Rule is eliminating intensive inpatient rehabilitation as a treatment option for a significant number of Medicare beneficiaries.

At the core of the 75% Rule seems to be a mistaken reliance on the assumption that one site of care can be substituted for another with no impact on quality or outcomes. In particular, CMS, in promulgating changes to classification criteria for IRFs, assumed that SNF and other post-acute care settings can be substituted for IRFs if patients are denied care due to the exclusion criterion in the 75% Rule, and that this is clinically acceptable and economically desirable. AMRPA strongly disagrees with this premise. IRFs provide a very unique, specialized, intensive form of rehabilitative care that cannot be duplicated in other Medicare settings. Given the enormous impact the 75 Percent Rule has had on inpatient rehabilitative care, AMRPA urges the Ways and Means Committee to consider legislation that would hold the 50% threshold for compliance for two additional years. Moreover, to facilitate collaborative relationships with federal policymakers, AMRPA urges consideration of a federal advisory council on medical rehabilitation that would work with CMS to properly characterize IRFs and separately establish workable guidelines to distinguish appropriate patient selection criteria.

#### ***Current Financing for Post-Acute Care Services***

Current Medicare program post-acute care policy is focused on providing care based on types of providers, with the key post-acute care institutional providers being LTCHs, IRFs and SNFs. While all of these sites provide post-acute care to Medicare beneficiaries, each site of care currently utilizes its own prospective payment system. The SNF PPS began in 1998 and is based on a per diem payment unit. SNFs use a patient classification system called resource utilization groups (RUGs), of which there are 44 groups. On May 19, CMS issued a proposed rule to change the RUGs and increase the number to 53. In contrast, the LTCH PPS is based on a per discharge payment unit and uses LTCH DRGs, of which there are currently 550. The LTCH PPS is being phased in over 5 years. Finally, the IRF PPS was initiated in January 2002 and is also based on a per discharge payment unit. There are 21 Rehabilitation Impairment Categories (RICs) and 95 case mix groups (CMGs) with four payment tiers, for a total of 380 possible CMGs and separate HIPPS codes. Each system is based on research reflective of the costs of care in a base year used to calculate the payment rates.

CMS, MedPAC and others have expressed concern that the post-acute care payment systems provide incentives for engaging in behavior solely to enhance reimbursement, without regard to quality or appropriateness of care, patient outcomes or cost. Policymakers must realize that looking at payments in the context of diagnoses only, without looking at other factors, can be quite startling but does not reveal much about patient differences and reasons why a particular setting (1) best suits the need of that patient and/or (2) contains the resources necessary to obtain the optimum patient outcome. For example, payment for a stroke case may vary from \$31,496.00 in an LTCH to \$8,905 in a SNF according to a MedPAC report in June 2004 examining the most severe stroke cases (Chapter 5, June 2004 report on LTCHs). However, since those figures are for the most severely ill types of patients in that diagnosis, the numbers cited do not reflect the average payment, which is considerably lower. For example, the average Medicare payment for a stroke in an IRF in 2003 was \$16,769.00 according to AMRPA's eRehabData®.

While federal policymakers understandably look closely at payment differentials, these payments encompass costs that are larger than the individual patient being treated. All of the payment systems discussed are based on historical costs that reflect not only patient care but also the setting-specific requirements and different Medicare Conditions of Participation each type of entity must meet. These requirements vary considerably by setting in the length, depth, scope and cost of compliance. Each system also relies on some patient's diagnosis information and varying amounts of functional information.

AMRPA has closely analyzed cost reports for SNFs and IRFs, examining both routine costs and ancillary costs in order to determine any differences between the two settings and whether such differences are representative of varying levels of services delivered. When the SNF PPS and IRF PPS were under development in 1998, AMRPA analyzed the available costs reports for 1996 to see what the impact of a prospective payment system would be on SNFs. AMRPA found that there were higher costs in hospital-based SNFs than freestanding SNFs, a finding later reaffirmed by MedPAC reports. These findings suggested that a different type of patient was being treated with more complex needs in the hospital-based SNF setting. At the time of the analysis, the average length-of-stay (ALOS) for the hospital-based SNFs was 16.56 days, in contrast to 45.03 days in the freestanding SNFs.

AMRPA also examined routine and ancillary cost differences between IRFs and SNFs. It was clear that both the routine costs and ancillary costs were higher in the IRF setting, reflecting the greater intensity of care. IRFs had higher ancillary

costs per day (\$274 per day for rehab units; \$134.74 for SNF hospital based units; \$268 for rehab hospitals; and \$118.96 for freestanding SNFs), as were specific therapy charges. However, we believe that ancillary costs have decreased in response to the SNF cuts and therapy cuts in the Balanced Budget Act of 1997 and the implementation of the SNF PPS. Such a decrease would reflect a reduction in the amount of therapy delivered and the intensity of care. AMRPA is currently working on updating this information using 2002 costs reports.

The cost differential between SNFs and IRFs is significant, but the cost variation represents differences in prospective payment systems and the greater intensity of care provided in the inpatient rehabilitation setting. Thus, the faulty belief that care is equivalent among post-acute care settings is also leading CMS to argue that Medicare is paying too much for some patient care provided in IRFs. In its September 9, 2003 proposed IRF rule, CMS assumed that the average payment for an IRF was \$12,525 and that by substituting care at a payment of \$7,000 per case it would “save” approximately \$5,525 per case. It is clear now that the cases being denied access to IRF care due to the 75% Rule are primarily lower extremity joint replacement cases whose payments on average in 2004, based on eRehabData®, were approximately \$9,151. Hence the actual difference in payments is only \$2,151 per case. Additionally, these numbers may also be misleading because of differences in lengths of stay. If the average Medicare SNF stay for similar cases is 31 in 2001 and 33 days in 2003 according to MedPAC, at an average daily rate of approximately \$400, then the payment is closer to \$12,000 thereby further reducing Medicare’s alleged savings. We would be pleased to provide the Committee with the AMRPA analysis.

#### ***Services Provided in IRFs Compared to Other Post-Acute Care Settings***

One frequent discussion in comparing settings is whether a nursing home or skilled nursing facility can substitute for IRF care and provide equivalent services and outcomes. Practitioners find that in general, nursing homes and skilled facilities do not have all the characteristics of an IRF. Facilities may share some characteristics with IRFs, but this varies widely geographically. IRFs are subject to a number of standards that no other post-acute care setting must meet, including: (1) close medical supervision by a physician with specialized training in rehabilitation; (2) patients must undergo at least 3 hours a day of physical and/or occupational therapy; and (3) a multidisciplinary approach to delivery of the rehabilitation program. (Please find attached a chart delineating a comparative analysis of SNF and IRF coverage criteria). There are no comparable specific standards for other facilities relating to rehabilitation services (such as the “three hour rule” for IRFs), and, therefore, each nursing home or SNF must be evaluated individually.

A good illustration of the difference in services provided in these rehabilitation settings can be seen in the Spring 2005 MedPAC analysis examining single hip and knee joint replacements in IRFs and SNFs. MedPAC commissioned the RAND Corporation to study outcomes across settings for hip and knee replacement cases in response to changes to the 75% Rule that would force fewer hip or knee replacement patients to be treated in IRFs each year. MedPAC staff conducted two studies and presented the results at the April 2005 meeting. The first study involved a physician panel of six (6) orthopedic surgeons and five (5) specialists in physical medicine and rehabilitation. The physician panel noted that close to 50–80% of such patients go home with home health care or outpatient services, and therefore not to institutional settings. The panel said that patients who could not go home should have the following characteristics for referral to a SNF or IRF:

- Be limited in weight bearing or unable to walk 100 feet;
- Be obese or have comorbidities;
- Have an impairment of one or more joints (not replaced);
- Have diminished pre-surgery functioning; or
- Have architectural barriers or no informal caregiver at home.

Panelists also said that patients who need extra medical attention should go to IRFs, while patients who need convalescent care or cannot tolerate 3 hours per day of therapy should go to SNFs. In some communities, surgeons refer based on the qualifications of specific facilities that are available, such as how the facilities are staffed, whether they follow rehabilitation protocols or are convenient for the surgeon to follow-up.

Another point MedPAC has clearly established is that the types of patients treated in each setting are considerably different. MedPAC recently examined the types of patients in SNFs, IRFs and home health agencies (HHAs) receiving care for single joint replacements. Specifically, it found that:

**Patient Populations Differ Across PAC Sites**  
**Acute Care Hospital**

Home (35%)	IRF (35%)	SNF (30%)
Youngest	Older	Oldest
Least complications	More complications	Most complications
Least comorbidities	More comorbidities	Most comorbidities
Highest SES	Lower SES	Lowest SES
Most knees	More knees than SNFs	Most hip replacements
Replacements	Shortest acute LOS	Longest acute LOS
	Higher functional scores at discharge (than SNFs)	Higher functional scores at admission (than IRFs)

\* MedPAC Staff Handout, April 2005 Meeting

RAND presented a number of conclusions about the differences in cost and care among settings. Generally, RAND found that the functional level of patients in IRFs was lower at admission than in SNFs, but patients ultimately had greater functional gains, suggesting that the greater intensity of therapy in IRFs improves functional status. In addition, after controlling for a number of variables, RAND found that SNF and IRF patients were more likely to be institutionalized compared to patients sent home. However, 2.5 times more patients in SNFs were institutionalized or died (0.46%) than those in IRFs (0.18%). Further, as expected, SNFs and IRFs were paid more than patients discharged home. RAND found that SNFs cost \$3578 and IRFs cost \$8,023 for total post-acute payments as opposed to home care. Note, however, that these figures are misleading and understated for home health costs and SNF costs because they do not include any Part B outpatient services provided.

AMRPA is particularly concerned that patients referred to LTCHs and IRFs are being pressured by Medicare into staying in acute care longer or treated in SNFs. This view has become much more prevalent as CMS issues regulations that are detrimental to certain sites of care, such as CMS's FY 2005 LTCH rate year update, the IPPS FY 2005 proposed rule proposal pertaining to hospitals within hospitals, and the various proposed and final rules pertaining to the 75% Rule for IRFs. Many post-acute care LTCH and IRF providers are left with the impression that a federal bias in defining LTCHs and IRFs more narrowly is designed to: (1) close many of these facilities; and (2) force patients to be treated in skilled nursing facilities (SNFs). Many post-acute care providers and physicians believe that while SNFs may be able to treat a percentage of such patients successfully with respect to outcomes, many are not able to successfully treat these patients because of serious differences in a patient's medical and functional abilities and the significantly more limited resources provided in SNFs.

CMS and Congress should actively initiate research on how these sites of care provide treatment to Medicare beneficiaries and how each site's functional outcomes vary by patient diagnosis. As noted by the National Institutes of Health's February 2005 panel on medical rehab and by MedPAC, there is little evidence on the different care provided by these entities and how outcomes differ by site of care. The Agency for Healthcare Research and Quality (ARHQ) conducted a literature review and found after reviewing 4600 studies, few studies are available on this topic<sup>1</sup> We call the Committee's attention to one timely published study that compared the outcomes of hip fracture patients treated in SNFs and IRFs. The study, "Effect of Rehabilitation Site on Functional Recover After Hip Fracture," by Munin et. al.<sup>2</sup> found that IRF patients had superior functional outcomes compared to those treated in SNFs when the same measurement tool was used. The improved outcomes occurred during a significantly shorter rehabilitation length of stay and remained even when statistically controlling for baseline differences between groups. The study called for further research to more fully understand the differences between rehabilitation treatment settings. Notwithstanding current available research, there is a signifi-

<sup>1</sup> An Assessment of Medical Literature Evaluating Patient Rehabilitation facility programs on conditions of interest, Agency for Healthcare Quality and Research, March 2005.

<sup>2</sup> Effect of Rehabilitation Site on Functional Recovery After Hip Fracture, Munin et.al, Archives Physical Medicine & Rehabilitation, Vol 86, pg. 367, March 2005.

cant need for prospective studies examining the provision of care among various settings providing medical rehabilitation services, SNFs, IRFs and LTCHs, to better determine how outcomes and treatment differ among these settings. We would be pleased to work with the Committee in developing these studies as well as working with our colleagues in the medical rehabilitation field to engage in research efforts.

#### ***Patient Assessment Instruments***

While post-acute care payment systems generate considerable data about each setting of care, the data is difficult to compare because each payment system uses a different data collection tool. At its March 2005 meeting, MedPAC examined the various data sets and realized that they cannot be easily cross-walked with each other in order to compare the patients, outcomes, and costs, other than to observe broad outcomes such as mortality and readmission to acute care. The LTCH PPS uses the standard UB 92 claim form. The IRF PPS requires each facility to complete the inpatient rehabilitation facility patient assessment instrument (IRF PAI) as well as the UB 92 for each case. The SNF PPS requires each facility to complete the Minimum Data Set (MDS) form for each patient and the UB 92. The UB 92 form, while common to all settings, collects information solely on diagnosis codes and does not include any functional information.

Because these settings serve different populations and do not have any common functional assessment tools, outcomes at this point can only be measured at a broad level that is not truly representative and fails to measure the full impact of a rehabilitation program. As noted above, certain observations can be made about mortality, readmission to acute care and institutionalization of patients for the long term when referred to certain settings, such as SNFs. However, in comparing these settings, there are significant limitations that were studied and acknowledged by MedPAC in its March 2005 discussion of post-acute care and patient assessment tools. RAND repeatedly cautioned about some significant deficiencies in the obtainable data that limited the findings of the study. First, controlling fully for selection is extremely difficult, and it is unclear whether the models capture this data in an accurate manner. Second, RAND was unable to conduct a substantive analysis of patient function; thus, the outcomes analyzed are not the ideal outcomes measures for joint replacement patients.

Similar to variances discussed in conjunction with the different payment systems, each tool used to assess diagnoses, comorbidities and medical functional status and cognitive status uses significantly different measurement items. As a result, today it is simply impossible to assess outcomes and quality of care at the level necessary to accurately and fairly compare the various sites of care.

#### ***Recommendations***

We think the issues facing policy makers, providers and patients relating to post-acute care payment and services would best be addressed through a broad, cross-site prospective study of these sites of care and the outcomes provided by their distinct treatment resources. Not only do Congress and CMS need to have comprehensive and accurate data before engaging in any sweeping payment structure changes, such data will be crucial if the federal government intends to take any substantive, meaningful action that will save the Medicare system money while still protecting the quality of care given to beneficiaries nationwide.

We recommend a multi-step approach to evaluating the state of post-acute care across settings for rehabilitation patients and implementing a new payment structure to capture the true costs of patient care. As mentioned above, measuring function is the critical aspect of understanding a patient's rehabilitation needs. The approach outlined below should be viewed as a framework and could be amended or added to other studies designed to lead to creation of a new payment structure:

1. *Data Collection:* CMS should use the IRF-PAI for data collection throughout the treatment sites in order to collect data and compare costs, patient characteristics, and medical and functional outcomes across sites. Such a uniform data collection tool is necessary to eliminate the problems with the various existing tools and create one assessment instrument to cross walk to the three different tools currently used in post-acute settings. Data should be collected at admission, discharge, and for a follow-up period.

2. *Creation of new Rehab Post-acute Care Groups (RPACGs):* New patient groups would be created using an expanded version of CMGs that would reflect function, age, diagnosis, LOS, and comorbidities for medical status, and the ICF conceptual approach. Expanded CMGs would then be matched with costs to create new Rehab Post-acute Care Groups (RPACGs) and to develop appropriate weights. The RPACGs would use a per discharge model using a discharge as the payment unit and episode of care. SNF and LTCH patients who are not discharged and who ex-

haust their Medicare days should be tracked separately even after they exhaust their care and go on private pay or Medicaid for one year in order to establish total costs for that period. Facility adjusters would be provided (wages, low income, rural, others), as well as special payment rules such as transfers, short stay, interrupted stay and outliers. The groups would be matched with cost to develop the complete set of new payment groups reflecting payment rates for various types of patients receiving medical rehabilitation. Payments would reflect patient characteristics (such as age, diagnosis, function, comorbidities, complications, length of stay, etc.) and resource use in whatever setting, eliminating the need to distinguish patients by current institutional sites or “silos” of treatment.

3. *Adjustments*: Adjustments would be made for facility specific costs as are currently recognized in all prospective payment systems (e.g. wages).

4. *Revision of Payment System*: Finally, after initial implementation, revision of the payment system would take place in order to provide bonuses for better functional outcomes.

As we know, therapy services, physician services and nursing services of varying intensity, length and costs are provided currently in these three inpatient settings. These three sets of services, especially the intensity of therapy services, are key to the success of a rehabilitation program. From a policy perspective it makes the most sense to reexamine this situation and realign the policies with the providers, payers and, most importantly, patients in mind.

AMRPA acknowledges that these ideas may appear quite radical, but we firmly believe that the study recommended here would help settle the current debates and assumptions and remedy recent action by CMS that is jeopardizing patient care. CMS and Congress should continue its efforts to engage all the stakeholders, public and private, state and national, involved in this issue. Each such entity has its own priorities and perceptions that will need to be addressed for any proposal to be effective and successful.

### **Conclusion**

AMRPA cautions against adopting a simplistic viewpoint that growth in post-acute care is simply a function of substitution of care, or adopting the attitude that “if you build it they will come.” CMS’s rationale to date in making these assertions about substitutability has been that since there are few studies on point, the assumption must be correct (*e.g.*, the absence of proof is the proof of absence). Most post-acute care providers vehemently disagree. We urge Congress to recognize that the federal government cannot adopt the improper assumption that these settings can provide similar outcomes at similar costs. One only needs to look at the enormously detrimental effects of the 75 Percent Rule to see that such a policy will ultimately be grossly adverse to patient outcomes.

We again commend the Committee for its interest in rehabilitation and post-acute care, and we look forward to working with you and your staff on these issues.

## **Inpatient Rehabilitation Facilities Provide a Rehabilitation Setting Distinguishable from Skilled Nursing Facilities**

### **COVERAGE CRITERIA**

**CMS assumes that post-acute rehabilitation care settings are readily interchangeable.**

**In doing so, CMS ignores the enormous difference between the two care settings and the improved outcomes that occur at IRFs.**

<b>Requirements</b>	<b>Inpatient Rehabilitation Facilities</b>	<b>Skilled Nursing Facilities</b>
Medical Supervision	IRFs are required to provide close medical supervision by a physician with specialized training or experience in rehabilitation.	A SNF patient’s care would usually require only the general supervision of a physician, rather than the close supervision which rehabilitation patients need
Availability of Rehabilitation Nursing	IRFs are required to supply 24-hour rehabilitation nursing. This degree of availability represents a higher level of care than is normally found in a SNF.	While a SNF patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.

**Inpatient Rehabilitation Facilities Provide a Rehabilitation Setting Distinguishable from Skilled Nursing Facilities—Continued**

**COVERAGE CRITERIA**

**CMS assumes that post-acute rehabilitation care settings are readily interchangeable. In doing so, CMS ignores the enormous difference between the two care settings and the improved outcomes that occur at IRFs.**

<b>Requirements</b>	<b>Inpatient Rehabilitation Facilities</b>	<b>Skilled Nursing Facilities</b>
Intensity of Care	IRFs must offer a relatively intense level of rehabilitation services. The general threshold for establishing the need for inpatient hospital rehabilitation is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy.	SNFs are only required to offer services on a “daily basis,” with no requirement as to amount of patient care.
Multidisciplinary Team Approach to Care	IRFs must use a multidisciplinary team approach to delivery of the rehabilitation program. At a minimum, a team must include a physician, rehabilitation nurse, commonly registered nurse, social worker and/or psychologist, and other therapists involved in the patient’s care.	No such multidisciplinary approach is required at a SNF hospital.
Coordinated Program of Care	IRF patient records must reflect evidence of a coordinated program of care, i.e. documentation that periodic team conferences were held with a regularity of at least every two weeks to assess the individual’s progress and consider the rehabilitation goals of the patient.	SNFs must only maintain a complete and timely clinical record of the patient which includes diagnosis, medical history, physician’s orders, and progress notes.
Significant practical improvement	Hospitalization after the initial assessment is covered only in those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time.	Services must be reasonable and necessary for the treatment, be consistent with the nature and severity of the illness or injury, and must be reasonable in terms of duration and quantity.
Realistic goals	The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment is achieving the maximum level of function possible.	Rehabilitation services must be “reasonable and necessary” to the ailment being treated. The SNF manual makes no reference to rehabilitation goals.

Sources: IRF—Medicare Benefit Policy Manual • 110.4 (Rehabilitation Hospital Screen Criteria)  
SNF—Skilled Nursing Facility Manual, Pub. 12, • 214 (Covered Level of Care)

**Statement of American Occupational Therapy Association,  
Bethesda, Maryland**

The American Occupational Therapy Association (AOTA) represents nearly 35,000 occupational therapists, occupational therapy assistants, and students of occupational therapy to promote the interests of the profession and patients. AOTA submits this statement for the record of the hearing on June 16, 2005 on the current financing and assessment of post-acute Medicare providers. Occupational therapists and therapy assistants work in post-acute care settings to increase the independence and quality of life of their patients.

Occupational therapy practitioners provide services in a variety of settings, including, long term acute care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and in the home (HHA). Occupational therapy is a health, wellness, and rehabilitation profession working with people experiencing stroke, spinal cord injuries, cancer, congenital conditions, developmental delay, joint replacements and surgeries, mental illness, and other conditions. It helps people regain, develop, and build skills that are essential for independent functioning, health, and well-being.

AOTA strongly supports maintenance of the full spectrum of post-acute care settings to assure that patients have choice, that health care dollars are used most efficiently, and that the best possible outcomes are achieved. With that said, AOTA also supports efforts to develop more consistent and comprehensive methods to determine patient needs for post-acute care and continuing research on best practices and protocols.

Occupational therapy professionals assist those with traumatic injuries—young and old alike—to return to active, satisfying lives by showing survivors new ways to perform activities of daily living, including how to dress, eat, bathe, cook, do laundry, drive, and work. It helps older people with problems like stroke, arthritis, hip fractures and replacements, and cognitive problems like dementia. In addition, occupational therapists work with individuals with chronic disabilities including mental retardation, cerebral palsy, and mental illness to assist them to live productive lives. By providing strategies for doing work and home tasks, maintaining mobility, and continuing self-care, occupational therapy professionals can improve quality of life, speed healing, reduce the chance of further injury, and promote productivity and community participation for Medicare beneficiaries.

Medicare provides health insurance for nearly 35 million people over 65 years old and 6 million people under 65 years old with permanent disabilities. Medicare benefits are expected to total \$325 billion in 2005, accounting for 13% of the federal budget. In post-acute care settings, Medicare expenditures are currently more than \$30 billion annually. It is critical for Congress to determine whether patients are being treated in the most appropriate post-acute care setting and whether Medicare dollars are being allocated appropriately. LTCHs, SNFs, IRFs, and HHAs have all experienced major changes over the past 10 years.

The multiple and ongoing changes to Medicare post-acute care payment policies creates a unique environment in which measuring the effect of service delivery is particularly difficult. One of the biggest changes is the implementation of new prospective payment systems (PPS) for each post-acute care setting. Each PPS varies in terms of key design features such as the unit of payment (per diem, per discharge, every 60 days), classification schemes (RUGs, HHRGs, and case mix groups), and patient assessment instruments and processes used for patient classification (MDS, OASIS, and IRF-PAI). Each of these payment systems were installed on different timetables, and each is being modified in different ways and at different times. Such fragmentation could affect the quality and outcomes of patients in post-acute care.

The policy concern that Medicare may be paying different amounts to different types of post-acute care providers for patients with similar care needs raises important questions for AOTA. How are we judging effectiveness? Have post-acute care providers worked to achieve the highest functional outcomes possible for its beneficiaries? What are the prospects and problems for moving ahead with a standardized assessment tool to evaluate the level of care a patient requires in each post-acute care setting? Will we create a system that does not have enough variation in options to achieve optimum goals for patients?

The focus of post-acute care includes medical stabilization as well as practical improvements in function, with discharge determined by the speed in which the person returns to a reasonable level of independence. Occupational therapists and therapy assistants work in different post-acute care settings providing varying intensities of therapy to best meet the needs of their patients. Occupational therapy services are considered reasonable and necessary when it is expected that the therapy will result

in significant improvement in the patient's level of function within a reasonable amount of time. With speedy discharge to return to normal activities an important aspect of post-acute care, function should be the governing assessment component across all settings. Where will the patient best regain medical stability but also regain ability to fully recover and return to activities? Occupational therapy is not only focused on lost function, but also improves a patient's ability to remain independent and sense of well-being which can contribute to better recovery following post-acute care. It is imperative that occupational therapy be an integral part of the development of the plan of care of people transitioning into post-acute care, in determining readiness for discharge and in developing discharge plans. Occupational therapists' and therapy assistant's success can be measured by the quality of life and level of independence of their patients once they are discharged. This should also be the measure of the effectiveness of Medicare dollars.

Each post-acute setting provides different levels of therapeutic intervention combined with differing levels of other care. Each setting has advantages for different types of patients. However, each post-acute care setting uses a different patient assessment instrument to evaluate the level of care a patient requires. This makes it difficult to know whether patients are being treated in the most appropriate setting and whether Medicare dollars are being allocated appropriately. Any standardized assessment should look at the distinct aspects and benefits of the services provided in that setting. A standardized assessment would need to focus on the differences in each post-acute care setting and the services provided there. A standardized assessment should also recognize the distinct differences and contributions of each needed service.

One significant problem faced by occupational therapists in post-acute care settings is the financial limitations on therapy imposed by Congress in the Balanced Budget Act of 1997. The legislation imposed a \$1500 annual cap on Medicare Part B outpatient occupational therapy alone and physical therapy and speech-language pathology combined. A 2-year moratorium was included in the Medicare Modernization Act of 2003 (P.L. 108-173), however, that moratorium will expire on December 31, 2005. Congress currently has before them a piece of legislation that repeals these therapy caps. However, current discussions have included a number of different options on how to address this piece of bad policy. AOTA has stressed the need to keep occupational therapy distinct and separate because of the uniquely beneficial service that occupational therapists and therapy assistants provide. Financial limitations to proper therapy services impede the therapists' ability to care for their patients appropriately and use professional judgment effectively.

Another critical issue for occupational therapy is the limitation experienced by occupational therapy practitioners in home health field because of an outdated and obsolete eligibility criterion. Beneficiaries must need one of three qualifying services—nursing, physical therapy, speech-language pathology services—to be eligible for the full home health benefit. Occupational therapy cannot be an initial qualifying service. As far back as March 1997, the former Medicare Prospective Payment Commission said that the "lack of a clearly defined benefit compromises" the program's ability to pay only for services that are reasonable, necessary and medically appropriate. AOTA believes that a key problem in the definition of the home health benefit is the qualifying service issue which may cause some patients to receive unnecessary physical therapy, for instance, when their need is for occupational therapy. The failure to recognize occupational therapy as an initial qualifying service limits the use of occupational therapy to conduct important activities including the initial OASIS. Legislative action is necessary to correct this; AOTA urges further study of how this could be changed in a cost effective manner.

Finally, AOTA commends the Subcommittee for taking the time to debate and learn more about the post-acute care system. Congress is in a position to create a system more tailored to the services required by patients rather a system that favors the setting in which patients are placed. AOTA looks forward to working with the Committee to better our nation's healthcare system.

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#### **Statement of John D. Shaw, Next Wave, Albany, New York**

I am a health systems researcher and policy analyst located in Albany, New York. Since the early '70s, I have been involved in the design, development, implementation, and evaluation of patient assessment, payment, and quality measurement systems for both acute and post-acute care. These projects have ranged from national pilot projects to develop the initial Diagnosis Related Group (DRG) and Resource

Utilization Group (RUG) payment systems and Quality Assurance/Quality Indicator (QA/QI) tools, to the design, evaluation, and refinement of state payment systems on the behalf of state Legislative and Regulatory branches, insurers, provider groups, and individual providers. We have also worked at the individual provider level to refine and implement internal Information Technology (IT) and manual systems and procedures to collect accurate data to support the payment and quality processes. My comments represent a synthesis of viewpoints gleaned from all of the stakeholders for whom I have worked over the years and a review of Subcommittee testimony—but as stated below, they are my own.

First, I agree with the Subcommittee that Congress and the Medicare/Medicaid programs must place a high priority on a payment system that focuses on meeting the individual patient needs rather than institutional settings that deliver services. Tool(s) common to all settings to assess patient needs and align payment for services to meet these needs are critical. We recommend:

- *Payments based on the patient episode*, with the same total payment regardless of setting for the same patient characteristics, including the acute care component where feasible.
- *A family of screening plus in-depth assessment tools*, with common definitions across all settings, can balance the need for precision to plan, provide, and pay for individual care needs, while NOT requiring an in-depth assessment of areas that do not apply.

Second, added features are critical to incorporate into the details of the above to overcome and avoid major controversies such as “cream skimming” (e.g. Physician Owned Specialty Hospitals), inconsistent payments for similar services (e.g. 75% Rule), and cost shifting to others (e.g. annual debates over Federal/State/Provider/Consumer share of cost.) These include:

- Incorporate into the assessments—all data fields needed to provide an evidence base to address the above controversies, rather than the current “battle of the hypotheticals.”
- *Mandate timely, transparent access to de-identified data details* to all key stakeholders to:
  - Overcome distrust of any findings that cannot be independently verified and
  - Allow for reconciliation of any conflicting findings from all viewpoints.
- Include measures for program focus and regional health care delivery environment as well as setting, e.g. a hospital-based Skilled Nursing Facility (SNF) in one region may be similar to an Inpatient Rehabilitation Facility (IRF) in another region, while others differ.
- *Incorporate elements from all current assessment tools* to facilitate accuracy and buy-in.

Some examples from current controversies help illustrate the need for the above recommendations. We focus on Hip and Knee Joint Replacement since it is a source of controversy in recent years, is a high volume and growing component of total health care expenditures, has a significant Post Acute Care (PAC) fraction, and spans multiple settings.

#### ***Consistent Time Frame and Case Mix Adjustment for Comparisons***

While the patient experiences (and Medicare/Medicaid pays for) an *entire episode*, policy comparisons over the past few years have been limited to selected portions of the episode, without appropriate adjustment for earlier and later contributors to overall episode costs. Some trade-offs that stakeholders assert include:

- Extending stays (and hospital payments) for 1–2 days so that some Knee replacement patients can negotiate stairs and go directly home could save institutional PAC costs.
- Patients also receive Home Health Care and Outpatient Rehabilitation after discharge from both IRFs and SNFs. The cost and frequency of these non-institutional services affect total payments and should be included in any policy debate.
- Consistent data to identify and predict the appropriate patient trajectory and costs are either lacking or not reported today.

#### ***Missing Data for Consistent Comparisons***

Major controversy is focused on post acute care for joint replacements in IRF/SNF settings.

- Obesity, particularly morbid obesity (BMI>40) is a major determinate of costs and quality risks. IRFs indicate that they have more of these patients than SNFs, who are a large driver of functional scores. SNFs indicate that they are not reimbursed for the higher care needs of these patients. However, the

IRF-PAI lacks height and weight and the MDS lacks the detailed functional scores needed to measure and validate either claim.

- Analysis to date to inform the controversy is inadequate to do so. Not only are comparable outcome measures unavailable, *volumes to compute materiality* and *consistent cost components* are also unavailable for comparison:
  - Examples of dollar differences between each setting *lack volume data*. We need this to differentiate whether the hypothetical patient represents all, most, some, few, or one-in-a-thousand. A difference that applies to *handful of patients somewhere* is very impact on the overall Budget than *most patients everywhere*. For example, a recent comparison uses a patient with septicemia, which appears to represent a fraction of one percent of joint replacement cases in either setting. Also, since SNF rates are per day, length of stay assumptions used in comparisons should be stated, and should be validated to confirm they are representative.
  - Costs included in bundled rates in each setting differ widely. For example, respiratory therapy and high cost pharmaceuticals used to treat patient clinical needs generate NO additional SNF reimbursement, while IRFs are typically paid an additional \$ 1,500 per case for clinical needs identified by “tier” payment add-ons. Economic realities and facility claims indicate wide variations; however, data to validate these claims are unavailable.

#### ***Transparent Access to Data Facilitates Reduction of Controversy***

We strongly believe that if more detailed evidence were shared between all stakeholders, they would have already have validated each others’ findings and reconciled differences. This sharing, however, may require further Congressional mandate.

#### ***Measures of Program Focus and Regional Health Care Delivery Environments***

Rehabilitation professionals identify two major subpopulations:

- Patients who desire and tolerate Intensive (3+ hours per day) rehab in 9–14 days are typically treated in IRFs, but a few SNFs also have short stay programs.
- Patients who can only tolerate lower impact (0.5–1.5 hours per day) rehabilitation Extended over 3–4 weeks are typically treated in SNFs.
- In addition, if family caregivers and safe housing resources are available, some patients can safely recover using home care and outpatient rehabilitation services.

In assessing PAC programs in both settings over the years, total costs for either approach in an institutional setting appear similar regardless of program and setting; however, payments could differ widely today. Failure to differentiate these program approaches makes overall comparisons of costs/outcomes invalid.

For example, in reviewing post acute care statewide in New York, we found that the predominate PAC setting for joint replacement patients in the New York City Metropolitan area, while hospital-based SNFs are the predominate setting in Rochester and Syracuse. Programs are fairly similar; however, the setting difference is driven by factors other than post acute care. Other payors, for example Blue Cross, have supported the programs historically, while currently these programs are cross subsidized by the hospital. In the New York City area, however, other payors have not supported PAC until recently, and there are few hospital based facilities to cross subsidize significant SNF losses.

There is even potential for Home Care, which is the predominate PAC setting in the Binghamton and Elmira areas. In these predominately rural areas, there are typically several generations of extended family living close by to provide assistance. In our own community around Albany, there is no predominate setting, rather, there are award winning free standing and hospital-based IRF and SNF programs, and quality home care services. In talking to patients and their families, only the program matters—most are not aware of the difference between an IRF or SNF based program. A number of recent studies in the literature have found similar patterns nationally. Any solution that assumes program availability in all settings in all geographic locations is contrary to available evidence and will cause local access problems for taxpayers in these areas.

#### ***Family of Comprehensive Assessments***

Screening tools to identify where added assessment is needed should incorporate major elements of existing setting tools the IRF-PAI for IRFs, the MDS for SNFs and the OASIS for Home Care, including for example:

- Case Management (including the patient’s own cognitive capabilities and desires) should combine local program availability with elements of all existing tools, with key additions such as height, weight, and smoking status,
- Housing needs and supportive assistance (home vs. institutional bed) from OASIS,
- Personal Care needs (ADL’s and IADL’s) from MDS and OASIS,
- Functional Status and Rehabilitation needs from IRF–PAI, and
- Medical/Clinical needs (therapy and non-therapy ancillary services, medical monitoring).

Case management can apply the overall screening tool and the appropriate detailed assessments to find the best “fit” for each individual resident, while at the same time providing consistent data for evaluation and future policy refinements.

The Institute of Medicine (IOM) recommended that financial and quality incentives be aligned in order to transform health care. Currently in today’s fragmented system of setting “silos”, the strategy for financial success is to identify flaws in today’s inconsistent regulatory structure, and then seek out windfall opportunities, while avoiding any underpayment gaps (and/or to shift the cost to someone else.) Where inconsistencies are identified between stakeholder estimates today, and lacking complete evidence, they are:

- At best—good faith estimates that are incomplete, inconsistent, wrong, and likely to continue controversy
- At worst—“Spin Wars” where the best hypothetical example wins
- Regardless of what is good for the patient and the Budget

Fixing these flaws will both close the gaps and reduce the ability and need to shift costs elsewhere. Providing consistent and complete evidence measures transparently to Congress, the Centers for Medicare and Medicaid Services (CMS), providers across all settings, and consumers will help focus the attention of all on pursuing quality and safe outcomes efficiently.

Thank you for the opportunity to contribute to moving toward setting evidence-based policy in this important area.

