The US Oncology Network

Submitted Testimony of Dr. Barry Brooks on

Keeping the Promise: Site of Service Medicare Payment Reforms

Energy and Commerce Health Subcommittee Hearing

May 21, 2014

Chairman Pitts and Ranking Member Pallone, thank you for the opportunity to testify today on behalf of The US Oncology Network[1] before the Energy and Commerce Subcommittee on Health on *the Medicare Patient Access to Cancer Treatment Act*, H.R. 2869, sponsored by Congressman Mike Rogers and Congresswoman Doris Matsui. Members of the Health Subcommittee have been especially committed to the nation's cancer patients and care providers over the years and many of the Members on this Committee can take credit for policies that have shaped our world-class cancer care delivery system. Thanks for your dedication and support for Americans and their families fighting cancer and for those of us who work to help patients live longer, happier, better lives.

I'm honored to be appearing before the Committee again. My name is Barry Brooks, and for the last 32 years I have spent the majority of my time taking care of cancer patients as a practicing oncologist. On an average day I work 12 hours and treat around 14-20 patients, in addition to the

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[1] The US Oncology Network is one of the nation's largest networks of community-based oncology physicians dedicated to advancing cancer care in America. Like-minded physicians are united through The Network around a common vision of expanding patient access to high-quality, integrated cancer care in communities throughout the nation. Leveraging healthcare information technology, shared best practices, refined evidence-based medicine guidelines, and quality measurements, physicians affiliated with The US Oncology Network are committed to advancing the quality, safety, and science of cancer care to improve patient outcomes. The US Oncology Network is supported by McKesson Specialty Health, a division of McKesson Corporation focused on empowering a vibrant and sustainable community patient care delivery system to advance the science, technology and quality of care. For more information, visit www.usoncology.com.

significant administrative duties that come along with taking a leadership role in my practice and The US Oncology Network. Slightly over 40 percent of my patients rely on Medicare and another 5-10 percent are either covered by Medicaid or are uninsured, but throughout the country over 60% of cancer patients rely on Medicare. Many seniors fighting cancer have more complex cases with co-morbidities and many also face difficulties navigating their care. Fortunately, community oncology clinics such as the one where I practice expand access for them with high-quality, state-of-the-art care close to home with lower co-insurance and other costs. So I am proud to be a small part of the most effective and successful cancer care delivery system in the world. And finally, after nearly 100 years of increasing cancer death rates in the United States, we have started to turn the corner in this fight: cancer mortality has fallen by 20 percent from a 1991 peak and cancer patients from around the world seek care here because Americans enjoy the best cancer survival rates in the world.

Despite significant progress in treatment and survival rates you all know that we still have a long way to go in beating this disease. The American Cancer Society estimates that in 2014 nearly 1.7 million Americans will be diagnosed with cancer and more than 585,000 will die of cancer, which is 1 out of every 4 deaths in America.

One of the main reasons cancer care works so well in America is the existence of a network of community based cancer clinics that provide patients with convenient, comprehensive, state-of-the-art cancer treatment close to home. Just a decade ago more than 85 percent of cancer patients were receiving their cancer treatment in community cancer clinics. However, in recent years we have seen a sharp decline in the availability of community based cancer care, leaving

cancer patients with fewer options and higher medical bills. Unfortunately, the crisis in community based cancer care has continued to worsen in the short time since I last spoke before the Committee.

I will use my time with you today to discuss why the nationwide network of community based cancer clinics are under so much strain and, more importantly, to explain how H.R. 2869 is an important first step to relieve this pressure in a way that is beneficial to patients, to care providers, and taxpayers.

I want to preface this by saying that every oncologist nationwide, regardless of where they practice medicine, will tell you that hospitals play a critical role in cancer care delivery, inpatient and outpatient. Each of us wants and expects quality acute care to be available at hospitals when we need it. Nor do I fault the many community oncologists throughout the country who have been forced to accept employment or other arrangements in hospital-based programs. It is not easy to run a vibrant independent practice these days with government-imposed hospital advantages and referral sources often owned by the hospitals as well. My testimony is not intended to diminish their choices or the value of the services they provide. Instead, I want to highlight the predictable, and unfortunately now realized, access and cost consequences to patients and the health system of an environment that financially favors hospital-based outpatient cancer care over the same quality care provided in community cancer clinics. Policymakers need not allow the continued destruction of the community cancer care patients need and prefer in order to continue to support hospital-based care. This unlevel playing field should be adjusted

by those who support patient choice and access to affordable, quality care so that patients have options among provider settings and locations.

Site of Service Shift over Recent Years

In 2005, over 87 percent of U.S. cancer patients received treatment in their preferred community clinic setting. By 2011, that number was less than 65 percent and today it is likely less than 60 percent. Over the past several years, the country has experienced a significant shift of outpatient cancer care delivery from the community to the hospital outpatient department (HOPD). Unfortunately, the data are clear: our world-class community cancer care delivery system is struggling to survive. Since 2008, 1,338 community cancer care centers have closed, consolidated, or reported financial problems; 288 oncology office locations have closed, 407 practices merged or were acquired by a corporate entity other than a hospital, and 469 oncology groups have entered into an employment or professional services agreement with a hospital.[2]

Also by 2011, a third of Medicare's outpatient chemotherapy and anti-cancer drugs had moved to the hospital setting, a more than 150 percent increase for HOPDs. As a result, Medicare spending on payments for chemotherapy administration services in HOPDs has more than tripled since 2005, while payments to community cancer clinics have actually decreased by 14.5 percent.[3] Sadly, the flight from community oncology did not end in 2011. Since early 2012,

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[2] Community Oncology Alliance Practice Impact Report, June 25, 2013. Online at: http://www.communityoncology.org/UserFiles/Community_Oncology_Practice_Impact_Report_6-25-13F.pdf

[3] Analyses of Chemotherapy Administration Utilization and Chemotherapy Drug Utilization, 2005-2001 for Medicare Fee-for-Service Beneficiaries; The Moran Company (May 2013), available at https://media.gractions.com/E5820F8C11F80915AE699A1BD4FA0948B6285786/01655fe9-7f3d-4d9a-80d0-d2f9581673a1.pdf

there has been a 20 percent increase in clinic closings and hospital acquisitions, which means increasingly more patients are facing reduced access and more expensive care.[4]

Year after year, as I watch colleagues being forced – either for financial or competitive reasons – to merge with a hospital, it has become clear that congressional action is necessary to halt the patient access and cost consequences that come along with the shift to hospital-based care. With reduced access to community cancer clinics, not only are patients forced from their preferred treatment setting, forced to drive further and wait longer, they are also charged more for the same service. In many cases, patients see the same physicians, nurses and caregivers in the same offices and sit in the same chairs, but pay significantly more because of the change in ownership and billing from physician practice to hospital outpatient department. In other cases of consolidation, outlying clinics are closed when they are too remote from the hospital facility to qualify for provider-based billing and purchasing, resulting in increased travel and hassle for patients trying to fight their disease. Patients fighting cancer should not bear the brunt of nonsensical policies that distort the health care system.

Differential Costs and Payment Rates across Outpatient Settings

Recent studies show that the shift to hospital outpatient cancer treatment has reduced patient access and increased costs to the Medicare program, taxpayers and patients. A 2011 Milliman study finds that the cost of treating cancer patients is significantly lower for both Medicare

[4] Community Oncology Alliance Practice Impact Report, June 25, 2013.

patients and the Medicare program when performed in community clinics as compared to the same treatment in the hospital setting. [5]

The study shows HOPD-based chemotherapy costs Medicare $6,500 more per beneficiary (over $623 million) and seniors $650 more in out-of-pocket spending per patient annually. Keep in mind, the median income of Medicare beneficiaries is less than $23,000. I ask the Committee today, why would we favor a system that requires the nation's most vulnerable to pay more for the exact same service, just in a different, less accessible setting? Put another way, why would we continually subsidize higher overhead costs and impose higher costs to cancer patients while at the same time underfunding the more efficient lower-cost community cancer offices?

Not only are HOPDs charging more for the same service, their spending is higher when caring for patients with the same diagnosis and stage of cancer. A new analysis of 2009-2011 Medicare claims data by The Moran Company indicates that by a variety of metrics, chemotherapy spending is higher at the HOPD than the physician office despite lower unit payment rates for drugs in the OPPS during that period [it is now equal in both settings at ASP+6% or +4.3% after considering the sequester impact]. Patients receive more chemotherapy administration sessions on average when treated in the HOPD—and the dollar value of chemotherapy services used is meaningfully higher in the HOPD. On a per beneficiary basis, HOPD chemotherapy spending was 25 to 47 percent higher than physician office chemotherapy spending across the 2009-2011

[5] K. Fitch and B. Pyenson, Milliman Client Report, Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy (Oct. 19, 2011), available

period and HOPD chemotherapy administration spending was 42 to 68 percent higher than physician office chemotherapy administration spending.[6]

In the face of this trend, the Centers for Medicare and Medicaid Services continued to widen the difference in reimbursement for the same services across outpatient settings this year. The 2014 Medicare Physician Fee Schedule rate for one hour of chemo infusion (96413) by intravenous therapy is $133.26, but the payment rate for the same service under the 2014 Hospital Outpatient Prospective Payment Schedule (HOPPS) is 125 percent higher at $299.53.

Building subsidies into HOPD payments for cancer care services to cover hospitals' indirect expenses associated with standby services does not appropriately target the added resources to those services. It also distorts pricing for outpatient services that require the same level of resource commitment regardless of the site of care. Such subsidies in combination with other site-specific Part B drug payment and policy issues have been major contributors to the rapid increase in hospital employment of physicians in general, and oncologists in particular.

Just this month, the IMS Institute for Healthcare Informatics released a study on innovations and cancer costs in the US. The report shows that Americans are increasingly paying higher prices because more patients are being treated by oncologists whose practices have been bought by hospitals, which may charge double or more for the same treatments. The report's authors calculated prices for 10 common chemotherapy treatments and found hospitals charged 189 percent more on average — or nearly triple — what the same infusions would cost in an

[6] Cost Differences in Cancer Care Across Settings, The Moran Company, August 2013.

independent doctor's office. The higher charges, which hospitals say are needed to support overhead and administrative costs, can often translate into steeper out-of-pocket costs for insured patients.

The May 2014 IMS report calculated that for commonly used cancer drugs, the average increased cost to the patient is $134 per dose if received in a hospital outpatient setting rather than in an oncologist's office. Alarmingly, the report also mentions that patients who face higher out-of-pocket costs are more likely to drop out of treatment, citing a study showing that a bump of as little as $30 in co-pays caused some breast cancer patients to skip or discontinue care. These types of discrepancies in reimbursement throughout oncology and other specialties greatly advantage hospital outpatient departments and subsidize their relative inefficiency. And if fighting to complete therapy and survive the disease weren't enough, cancer patients experience a financial toxicity associated with their diagnosis: they are 2.65 times more likely to file for bankruptcy than people without a cancer diagnosis.

MedPAC Recommends Site Neutral Payments

In its June 2013 report, the Medicare Payment Advisory Commission (MedPAC) recommended leveling the playing field for outpatient services, including oncology services. In the report, MedPAC highlighted the large disparities in payment in outpatient settings and noted that the payment variations across settings should be addressed quickly due to the fact that current disparities have created incentives for hospitals to buy physician practices, driving up costs for the Medicare program and for beneficiaries in a manner that cannot be easily reversed later. The report says alignment of outpatient reimbursement makes sense for services that can be

successfully and safely carried out in a physician's office, are infrequently provided in emergency rooms, involve average patient severities that are no greater in the hospital outpatient setting than in freestanding offices, and do not involve significant differences in resources as a result of packaging under the HOPPS.[7] Most cancer care services fit this description.

The history of successful community-based cancer care establishes that successful, cost-effective outpatient oncology services do not require hospital-based delivery. MedPAC concluded that hospitals should not automatically be paid higher rates for services appropriate for delivery in physician offices simply because hospitals incur higher indirect costs associated with other services that must be provided 24 hours a day and 7 days a week, or provided to patients with higher acuity or additional legal requirements that largely focus on emergency room and inpatient care.[8]

340B Drug Discount Program and Other Hospital Advantages

In addition to these code and service specific payment differentials outlined by MedPAC, hospitals enjoy other advantages relative to government policies around Medicare Part B drugs that push more patients and physicians into that setting. Approximately, one third of US hospitals purchase chemotherapy drugs through the 340B program at discounts of up to 50 percent, typically more than 30 percent below the Medicare reimbursement rate in the physician setting.[9] For 340B hospitals, the margin on Medicare drugs is over 30 percent, where for community clinics the margin is zero to negative 2 percent. With these high margins, it is no

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[7] MedPAC, Health Care and the Health Care Delivery System, Chapter 2, *Medicare payment differences across ambulatory settings* (June 2013).
[8] 78 *Fed. Reg.* at 43296.
[9] OIG Memorandum Report: Payment for Drugs Under the Hospital Outpatient Prospective Payment System OEI-03-09-00420, October 22, 2010. Online at: http://oig.hhs.gov/oei/reports/oei-03-09-00420.pdf

wonder that drug spending is increasing so rapidly in the hospital outpatient setting and that care is moving in that direction.

Another long-standing challenge with Medicare payments for Part B drugs and services concerns the patient coinsurance responsibility and other out-of-pocket costs that many seniors are unable to pay. It is rare for physician practices to be able to collect the entire Medicare allowable rate for Part B drugs and services because of the 20 percent coinsurance obligation facing beneficiaries, often for very expensive therapies. The experience of the US Oncology Network has been that approximately 25 percent of the coinsurance amounts (approximately 5 percent of the Medicare allowable) due to practices are uncollectible and end up as a direct expense of the practice. HOPDs offering cancer care services likely experience similar collection issues, but a significant portion of their incurred bad debt is reimbursed by Medicare. Physician practices receive no such relief; rather, they must shoulder the entire burden of bad debt when Medicare beneficiaries are unable to pay, or to pay in full, their Part B deductible and cost-sharing obligations.

A substantial portion of hospitals also operate without the burden of federal and state taxes. In contrast, community cancer clinics receive no reimbursement for uncompensated care, must pay taxes and must pay the full cost of all the drugs administered to patients, even when they cannot collect the full reimbursement from payers and patients.

Conclusion

The National Cancer Institute estimated that there were approximately 13.7 million Americans living with cancer in the U.S. last year. About 8 million of those are over the age of 65 and approximately half of all cancer spending is associated with Medicare beneficiaries.[10] As the baby boomers continue to reach 65 these numbers will only increase. Now is the time for Congress to act to ensure the future of community based cancer care and stop the site of service shift into more costly hospital outpatient departments.

When clinics close their doors or raise their prices, access to care is compromised for all cancer patients, but especially for vulnerable seniors. This shift to hospital–based care doesn't just reduce access to care for cancer patients, it also increases costs to Medicare, taxpayers and patients. These differences are even greater for care covered by private insurers. There is no clinical justification for migration of outpatient cancer care to the hospital setting. Patients don't want to be in a hospital and there is no practical or clinical advantage for driving care into a more expensive setting.

The US Oncology Network knows the Committee is familiar with this facet of the problem and has supported policies to equalize evaluation and management (E/M) payments across care settings. We strongly support the current bipartisan efforts by Congressman Rogers and Congresswoman Matsui to take an urgent approach to site-neutral payment for oncology services. At a time when access and cost issues are intertwined, we appreciate their collective belief that payment amounts be commensurate with actual services provided, not the site of care. Preferentially paying higher amounts in certain settings will predictably lead to the expansion of

[10] Mariotto AB, et al. Projections of the Cost of Cancer Care in the United States: 2010–2020, J Natl Cancer Inst 2011;103:1–12. Online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107566/

higher cost centers. The result will be further increases in the cost of cancer care for those who pay for it – patients along with private and government payers.

In fact, a strategy I encourage the Committee to explore would be to move toward the creation of a single outpatient fee schedule for all outpatient services regardless of the provider. As hospitals continue to acquire and purchase primary and specialty physicians, the cost of health care services will continue to rise while creating serious access problems nationwide. By removing the incentive for hospitals to purchase physician practices and charge more, physicians and hospitals will be able to compete on a level playing field on the basis of quality and cost, allowing patients to have greater options in their health care delivery system that cost less.

Additionally, I would just like to highlight and thank the several Members of this Committee that have written legislation and signed onto letters that assist in preserving community cancer care. Specifically, H.R. 800, sponsored by Congressmen Whitfield, Green and DeGette and 65 additional co-sponsors, would result in a more accurately aligned Part B drug reimbursement by removing any discount between the manufacturer and distributor that is included in the ASP formula but not passed on to the provider. Over 30 Members of this Committee signed a letter to CMS questioning how the Administration handled the sequestration cuts on Medicare Part B drugs, while Congresswoman Ellmers introduced H.R. 1416 and garnered 112 co-sponsors which would remove the outsize impact of the administration's decision to apply the 2 percent sequestration cut to not only the services community oncologists provide, but also the underlying cost of cancer-fighting drugs physicians purchase on behalf of Medicare and administer to seniors. This cut is in effect a 28 percent cut to the payments Medicare makes to community

clinics for handling, storing, mixing and preparing drugs for administration, and in conjunction with the prompt pay discount problem and uncollectible patient coinsurance, makes Medicare Part B drugs at best a break even proposition for community cancer clinics. On behalf of all of the community cancer clinics struggling to keep the doors open, I urge the Committee and the Congress to enact these three pieces of legislation to sustain community oncology. Without your action, cancer clinics will continue to close and care will continue to shift to the more expensive, less accessible hospital outpatient setting. Americans fighting cancer will experience diminished access to care, and patients, payers and taxpayers will pay more.

The primary purpose of a doctor is to relieve suffering. My oncologist colleagues across the country and I are doing our best, but in order to continue to provide the world's best cancer care here in America, we need your help. Once again, thank you again for the opportunity to address the committee. I am happy to answer any questions the committee has regarding my testimony.

House Committee on Energy & Commerce – Subcommittee on Health
"Keeping the Promise: Site of Service Medicare Payment Reforms"
Wednesday, May 21, 2014 – 2123 Rayburn House Office Building

Testimony of Dr. Steven Landers, MD, MPH
President & CEO, VNA Health Group

Good Morning Chairman Pitts, Ranking Member Pallone and Distinguished Members of the House Subcommittee of Health. My name is Dr. Steven Landers, and I serve as the President and CEO of the Visiting Nurse Association (VNA) Health Group. Thank you for this opportunity to offer my perspective on how thoughtful Medicare reform can help keep the promise our nation has made to her senior citizens.

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

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

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

Finally, I serve as Chairman of the Alliance for Home Health Quality and Innovation and serve on the Boards of Directors of the Community Health Accreditation Program, the American Academy of Home Care Medicine, the Greater Newark Health Coalition, the New Jersey Hospital Association Health Research and Education Trust, and the Partnership for Quality Home Healthcare. The Partnership, which I am pleased to represent here today, is a coalition of leading skilled home healthcare providers dedicated to advancing policy solutions that improve the quality of care and life for all home healthcare patients as well as greater efficiency and stronger program integrity for the Medicare program on which they depend.

Given the important focus of today's hearing, I would like to offer my perspective as both a medical professional and home healthcare provider. As this Committee knows, more than 1 million physicians, nurses, therapists and other caregivers across America are working every day to deliver complex medical services to an estimated 3.5 million Medicare home health beneficiaries. What is less commonly known is that this population one of the most vulnerable in our nation. Recently, Avalere Health conducted an analysis of the Medicare Current Beneficiary Survey (MCBS) Access to Care File, a national representative survey of the Medicare population, and found that Medicare home health beneficiaries are older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined:

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

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

Members of this vulnerable population include stroke survivors who must relearn how to walk, talk and eat again, as well as senior citizens and disabled Americans with Multiple Sclerosis, Alzheimer's, chronic obstructive pulmonary disease (COPD), and other complex chronic conditions.

Skilled home healthcare is essential to these vulnerable Americans and their families – it addresses their complex clinical needs in the safety and dignity of their homes, enabling them to remain in their community rather than undergo institutionalization. On a personal level, home health professionals also serve as a ray of light in lives of these Americans, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay close to family and community supports.

Home healthcare is also essential to the sustainability of the Medicare program and to the millions of taxpayers who provided critical financing to it. As is well-known, our society is aging – thousands of 'Baby Boomers' are turning 65 every day, and it is projected that the Medicare population will reach 70 million in 2030, just over 15 years from now. This dynamic poses immense challenges to the Medicare program and our nation as a whole. Simply put, we *must* explore creative ways that will enable us to keep the promise made to our senior fellow citizens without putting our nation's fiscal future in jeopardy.

I firmly believe that Home Healthcare has an important role to play, and we stand ready to do so. The driving purpose of home health is to help seniors stay healthy at home. The complex, specialized nursing services we deliver every day not only enables our patients to avoid medical complications and return to health – they avoid institutionalization that would substantially increase costs to Medicare and taxpayers. As has been well documented, home healthcare services are significantly less costly to deliver than those in institutional settings. As a result, it's not just that there's no place like home – there's also no place less expensive than home.

Despite the value that skilled home healthcare professionals already provide and the difference we are making in the lives of our patients, we believe we can do even more for the Medicare program and the nation. Our ability to

do so today, however, is constrained by a variety of challenges that serve as obstacles to greater efficiency and even better outcomes. These constraints include:

- A payment system that is so complex and burdensome it borders on nonsensical;
- Unchecked program integrity issues, especially in certain locations that consistently demonstrate aberrant utilization patterns;
- The requirement that a senior must be so infirm as to be deemed homebound before she or he is permitted to receive medical care at home;
- Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home; and,
- A siloed payment system that impedes care coordination and creates bureaucratic obstacles to quality and efficiency.

It is for these reasons that we so appreciate your development and consideration of reforms that can achieve significant improvement in the lives of vulnerable Americans and the Medicare program on which they depend.

The BACPAC proposal is a compelling example of such positive reform. Through the creation of a clinical condition-specific, site-neutral payment model for post acute care services, BACPAC represents a very important step forward for the Medicare program. In contrast to the challenges which compromise post-acute care today, the BACPAC model is designed to:

- Break down the barriers that today impair quality and produce inefficiency;
- Foster care coordination across today's siloes and among multiple providers;
- Enable mobile and homebound seniors alike to remain where they want to be – home;
- Permit investment in technologies and innovations that will lead to truly connected care; and,
- Achieve significant savings that can be utilized for Medicare program improvements such as reform of the Sustainable Growth Rate (SGR) formula.

Among these laudable attributes are three that I believe deserve specific mention.

First, the approach embodied by BACPAC would foster care coordination in a manner that I believe is essential if the Medicare program is to evolve in the best interests of patients and taxpayers alike. Today, there is too little coordination – a problem that begins even prior to a patient's discharge from a hospital and which manifests itself in the weeks and months that follow. Too often, the result is the delivery of care that is less effective, more disjointed, and far more costly than is necessary and which is delivered in a setting and manner that is not preferred by the patient and her or his family.

By contrast, the BACPAC model would foster care coordination across today's post acute care siloes and amongst a broad array of participants, including the hospitalist and discharge planner, the patient's physician, and the many physicians, nurses, therapists and other members of the post-acute care spectrum. BACPAC has the potential to unite these disparate elements due to its establishment of a single site-neutral bundled payment for each distinct clinical condition and its placement of responsibility for management of that bundled payment (and attendant risk assumption) with Coordinators and their comprehensive networks of medical professionals. Free from the artificial barriers that today impede collaboration and connectedness, this model would foster collaborative management of patients within these networks throughout the 90 days following discharge. As indicated by demonstration programs now underway, such a structure can have a transformative effect on patient care and outcomes as well as operational and program efficiency. And as MedPAC has noted, "Bundled payments ... encourage providers to coordinate care to focus on managing patient outcomes and controlling costs."[2]

Second among the features I would like to address is innovation. Today, a concerning gulf separates technological advances and their integration into at-home healthcare. Put another way, we are experiencing a real renaissance in the development of technological innovations that can improve patient care, outcomes and safety. As I wrote in the *New England Journal Medicine*, an example of these innovations is the ability of physicians to "arrive at patients' homes with a new version of the black bag that includes a mobile x-ray machine and a device that can

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

perform more than 20 laboratory tests at the point of care."[2] And yet, antiquated Medicare regulations and payment rules compromise the ability of providers to utilize technologies.

Unfortunately, the Medicare program neither provides support for nor takes into account the cost of such technologies in the home setting. In fact, Medicare does not allow telehealth to be used as a substitute for covered services, provides no funding for telehealth in the home setting, and prohibits home health agencies from even including telehealth expenses in their cost report. As a result, thousands of small home health providers that do not have the resources to undertake efforts similar to ours are unable to make them available to the many seniors they serve. This means, therefore, that the potential for at-home technology is being realized today to a far smaller degree than is possible and optimal.

The BACPAC model can help rectify this problem. By authorizing the use of funds for innovations that can improve outcomes and reduce cost – such as telehealth technologies – BACPAC would bridge the gap that exists today. Further, by placing risk and the potential for gain-sharing with Coordinators and their contracted networks of providers, BACPAC creates a powerful incentive to invest in technological advances precisely because they can do a great deal to reduce cost. As a result, we view this as very positive for patients, providers and, by extension, the fiscal sustainability of the Medicare program as a whole.

Last but absolutely not least, I wish to address the matter of patient choice. As stated previously, home healthcare professionals are dedicated to delivering compassionate, quality medical treatment to seniors so they may stay with their families and in their community. We believe this is vital because we know that it's what seniors want. As AARP has consistently documented, more than 9-in-10 American seniors wish to age in the comfort, safety and dignity of their home – not in an institutional setting. As a result, we believe that seniors' choices must not only be preserved but strengthened in any reform that Congress may contemplate.

In our view, the BACPAC model adheres to this objective. As proposed, this legislation ensures that seniors and their families would be able to exercise the freedom of choice. Specifically, patients would have the freedom to

choose their coordinator and, thus, their network of providers. In addition, patients would also have the freedom to choose from among the providers in their selected coordinator's network. Further, the BACPAC model would actually expand the options available to seniors by reducing some of the unnecessary barriers – like the three-day stay and the homebound requirement. As a result, a patient who, for example, is not homebound but would like to receive medical treatment at home would be able to do so – today, they cannot. We believe this thoughtful approach to post-acute care reform will enable patients to receive the medical treatment they need in the most appropriate setting that they are comfortable in.

Before closing, I would also like to take this opportunity to commend the Committee for its work on related policy priorities. In particular, I would like to thank you for the focus being given to payment reform that would replace the indiscriminate harm being imposed by across-the-board rebasing cut with value-based purchasing that achieves savings via reduced rehospitalizations. Rebasing, as implemented by the Department of Health and Human Services, threatens to undermine the very home healthcare delivery system on which post-acute care reform will depend. Confronted with 3.5 percent annual cuts in 2014, 2015, 2016 and 2017, many providers are being forced to make a decision being closure, consolidation or sale – each of which threatens to limit access to the high-quality, cost-effective home healthcare services that seniors need and prefer. As a result, the focus being given to value-based purchasing as an alternative source of savings is not only superior public policy – it is giving many in my community a reason for hope in an extraordinarily difficult time.

Similarly, your continued focus on program integrity reform is worth special mention. The Partnership has long asserted that change is needed not just to recoup funds that are paid to what we call the "fraudulent fringe" but to prevent the payment of aberrant claims in the first place. To help achieve this outcome, the Partnership developed a tough package of reforms known as the *Skilled Home Healthcare Integrity and Program Savings* (SHHIPS) Act. We are very grateful for the consideration being given its provisions and are hopeful that some if not all of it may be incorporated into future legislation so that the integrity of the program on which our senior citizens depend can be fully assured.

In closing, I would like to thank you again for convening this hearing and the privilege of participating in it. America's seniors deserve a Medicare program that provides high-quality preventive, therapeutic, rehabilitative and palliative care, and they want Medicare to be a program that will not burden their children and grandchildren with unsustainable costs.

These outcomes need not be mutually exclusive – we *can* have a high-quality *and* cost-effective Medicare program, but achieving both outcomes will require thoughtful and transformative reform. I applaud you for tackling the difficult challenge of crafting such reform. I also wish to express our appreciation and respect to Congressman David McKinley and his staff for their extraordinary work on this complex and important issue. Speaking not solely for myself or the Partnership but the home health community as a whole, I wish to assure you we stand ready to serve as a resource in your important work to Keep the Promise for America's seniors.

Thank you.

House Committee on Energy & Commerce – Subcommittee on Health
"Keeping the Promise: Site of Service Medicare Payment Reforms"

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Testimony of Dr. Steven Landers, MD, MPH
President & CEO, VNA Health Group

Summary

Home Healthcare: Essential to America's Most Vulnerable Seniors

- Today, more than 1 million physicians, nurses, therapists and other caregivers are delivering complex medical services in the homes of the most vulnerable seniors in Medicare.
- The population we serve is documented as being older, poorer, sicker and more likely to be female, minority and disabled than all other Medicare beneficiaries – combined. Examples:
  - Stroke survivor relearning how to walk, talk and eat again.
  - Seniors and disabled Americans with MS, Alzheimer's and complex chronic conditions.
- HH professionals are a ray of light in their lives, delivering medical treatment with compassion, tenderness, and professional skill that enables seniors to stay in their homes and communities.

Home Healthcare: Also Essential to America's Taxpayers and Sustainability of the Medicare Program

- America is aging – 10,000 Boomers entering Medicare every day; 70 million in just 15 years.
- HH is key to helping them remain independent, in the dignity of their homes and communities.
- Our priority is to help seniors stay healthy at home, avoiding costly institutionalization.
- It's not just that there's no place like home – there's also no place less expensive than home.

Home Healthcare: A Vital Tool that Can Do Even More

- Despite the value we already provide and the difference we are making, we can do even more.
- Today, we are burdened by challenges and obstacles to efficiency and even better outcomes:
  - A payment system that is so complex it borders on nonsensical.
  - Program integrity issues, esp. in certain locations with aberrant utilization patterns.
  - The requirement that a senior must be homebound to receive medical care at home.
  - Arbitrary payment cuts that indiscriminately impact vulnerable seniors, women, jobs, small businesses, technology, and our ability to help people stay healthy at home.
  - Siloed payment system that creates bureaucratic obstacles to quality and efficiency.
- It's for these reasons that we are excited about the reforms that you are considering.

Reforms Now Under Consideration Offer Tremendous Promise for Improvement

- BACPAC model offers the potential to address these challenges in a significant way.
  - Breaks down the barriers that today impairs quality and imposes inefficiency.
  - Fosters care coordination across today's siloes and among multiple providers.
  - Enables mobile and homebound seniors alike to remain where they want to be – home.
  - Permits investment in technologies and innovations that will lead to truly connected care.
  - Achieves tens of billions in savings that can be utilized for much-needed SGR reform.
- We also applaud the work being done on other policy priorities, including:
  - Payment reform that would replace the indiscriminate harm being imposed by rebasing with value-based purchasing that achieves savings via reduced rehospitalizations; and
  - Program integrity reform that would stop fraud by preventing payment for aberrant claims.

In closing, Home Health stands ready to help as you embark on this critically important journey, and we look forward to joining you in 'Keeping the Promise' for America's seniors.

WRITTEN TESTIMONY OF PETER W. THOMAS, J.D.
COALITION TO PRESERVE REHABILITATION
"KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS"
HOUSE ENERGY & COMMERCE HEALTH SUBCOMMITTEE

On behalf of the Coalition to Preserve Rehabilitation, a consumer-led coalition of 30 rehabilitation and disability organizations, my testimony will focus on the post-acute care ("PAC") site-neutral payment proposal and broader PAC bundling reforms. CPR believes that rehabilitation is the linchpin to improving the health, function, and independence of Medicare beneficiaries and, as such, is a cost-effective service. All settings of PAC services play an important role in the treatment of Medicare beneficiaries after an injury, illness, disability, or chronic condition. But these settings are not the same in terms of patient outcomes and it is critical to preserve access to rehabilitation at varying levels of intensity and coordination.

All Medicare PAC reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in PAC settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries' individual medical and rehabilitation needs, simply to save funds.

CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients' diagnoses, not based on their individual medical and functional needs. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Our testimony details a number of specific suggestions to improve the Bundling and Coordinating Post-Acute Care ("BACPAC") Act of 2014 in a manner that protects some of the most vulnerable Medicare beneficiaries under a bundled PAC payment system.

CPR supports the collection of uniform data across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. We support existing bipartisan efforts to develop a uniform quality assessment instrument to measure functional and quality of life outcomes across PAC settings. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries.

WRITTEN TESTIMONY OF

PETER W. THOMAS, J.D.
ON BEHALF OF THE

COALITION TO PRESERVE REHABILITATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITED STATES HOUSE OF REPRESENTATIVES

IN CONNECTION WITH ITS HEARING ON

"KEEPING THE PROMISE: SITE OF SERVICE MEDICARE PAYMENT REFORMS"

MAY 21, 2014

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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to testify on behalf of the Coalition to Preserve Rehabilitation ("CPR") on the issue of site-neutral payments under the Medicare program. I will confine my testimony to post-acute care ("PAC") services. My name is Peter Thomas, and I help coordinate the CPR, which is a consumer-led, national coalition of patient, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with disabilities, injuries, or chronic conditions may regain and/or maintain their maximum level of health and independent function. Members of the CPR Steering Committee include the National Multiple Sclerosis Society, the Center for Medicare Advocacy, the Brain Injury Association of America, United Spinal Association, and the Christopher & Dana Reeve Foundation.

Like many Americans who have sustained a serious injury or illness, I know firsthand the value of rehabilitation. When I was ten years old, I was involved in a car accident and lost my legs below the knees. I spent two and half months in Craig Rehabilitation Hospital in Denver, Colorado and returned home walking on two artificial limbs. Since then, I have undergone additional surgeries, outpatient rehabilitation, and have used thirteen sets of prosthetic limbs over the past forty years. As a result of quality rehabilitation and good prosthetic care, I was able to become an attorney and advocate on behalf of people with disabilities. I would hope that every Medicare beneficiary, indeed all Americans, have the same access that I did to quality rehabilitative care when they encounter an injury, illness, disability, or chronic condition.

Long term acute care hospitals ("LTACH"), inpatient rehabilitation hospitals and units ("IRFs"), skilled nursing facilities ("SNFs"), and home health care agencies all play an important role

in the recovery and rehabilitation of Medicare beneficiaries.[1] The services provided in each of these settings cater to beneficiaries with a particular set of medical and functional needs which are rarely defined by primary diagnosis alone. All Medicare post-acute care reforms based on site-neutrality that Congress considers should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. This is, of course, much easier said than done. Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform data needs to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including any site-neutral or bundled payment system that impacts some of the most vulnerable Medicare beneficiaries. It is one thing to maintain or improve quality outcomes while making the system more cost-efficient. It is quite another to ultimately save money in post-acute care by redesigning payment and delivery systems in a manner that does not protect against stinting on patient care and diverting beneficiaries into the least costly setting.

CPR strongly believes that any legislative changes to the Medicare program should not have the effect of restricting access to rehabilitation provided in post-acute care settings. Congress should avoid proposals that will lead to a reduction in Medicare rehabilitation benefits or that erect policy barriers that affect beneficiaries by channeling them into settings of post-acute care that do not meet the beneficiaries' individual medical and rehabilitation needs, simply to save funds. In this testimony,

[1] Although these settings are commonly referenced when discussing post-acute care policy, there are other providers in the post-acute care continuum that are critical to a well-functioning system. For instance outpatient therapy, hospice providers, durable medical equipment, prosthetics, orthotics, and supplies all contribute to the Medicare-covered set of post-acute care services. In addition, there are other specialty rehabilitation providers (whether or not Medicare covers these services) that focus on specific conditions, such as residential/transitional treatment programs for people with moderate to severe acquired brain injuries.

I will discuss rehabilitation and the Medicare beneficiary, and our specific views on "site-neutrality" and bundling proposals under the subcommittee's consideration.

Rehabilitation and the Medicare Beneficiary

Millions of individuals with injuries, illnesses, disabilities, and chronic conditions rely on the Medicare program for access to the rehabilitation services they need to improve their health, functional ability, and live as independently as possible in their homes and communities. According to the Centers for Medicare and Medicaid Services ("CMS"), more than two-thirds of Medicare beneficiaries, or approximately 21.4 million individuals, had at least two chronic conditions in 2010.[2] There are over eight million Medicare beneficiaries under the age of sixty-five who qualify for the program based on their disability status. Many people or beneficiaries with all kinds of injuries and illnesses avail themselves of both inpatient hospital and outpatient rehabilitation services at some point in their lives. For all Medicare beneficiaries, the Medicare rehabilitation benefit is a lifeline to improved health and functional status, and enhanced quality of life. And yet, growth in Medicare spending has been extremely low over the past three years: approximately 1.9 percent annually on average.

While spending has grown significantly in some post-acute settings over the past decade, Medicare spent the same amount on inpatient hospital rehabilitation in 2005 as it did in 2011, with a modest uptick in spending in more recent years, according to the CMS Office of the Actuary.[3] Timely, intensive, and coordinated rehabilitation provided in a rehabilitation hospital or unit decreases unnecessary long term dependency costs to the federal government. It also returns beneficiaries to their homes and communities, decreases the need to shift costs onto the states by relying on Medicaid

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[2] *CMS Chartbook 2012: Chronic Conditions Among Medicare Beneficiaries*, CMS, 6 (2012), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.

[3] CMS Office of the Actuary as cited by Mark E. Miller, Ph.D., Medicare Payment Advisory Commission testimony on Medicare Post-Acute Care Reforms, June 14, 2013.

as the payer of last resort for long term nursing home care that might have been averted with early, intensive and coordinated rehabilitation. This level of care is also the linchpin to reduction of costly and unnecessary hospital readmissions for beneficiaries with a wide range of debilitating conditions.

Site-Neutral Payment Proposal

CPR is grateful that Congress, in its most recent legislation to adequately compensate physicians serving Medicare patients and extend the exceptions process to the Medicare outpatient therapy caps, chose not to adopt a major site-neutral PAC proposal that was included in the President's most recent budgets and discussed in-depth in recent MedPAC reports. CPR opposes the site-neutral IRF-SNF proposal to equalize payments for certain conditions as it is little more than an outright financial disincentive for inpatient rehabilitation hospitals and units to accept certain Medicare patients based solely on patients' diagnoses, not based on their individual medical and functional needs. Implementation of site-neutral payment for patients with hip fractures, joint replacements and other conditions such as stroke would simply eliminate access by erecting financial barriers to admit these individuals in inpatient rehabilitation hospitals and units. Admission decisions and treatment plans should not be based on arbitrary Medicare rules, but rather on the clinical needs of individual patients in terms of amount, duration, intensity, and scope of rehabilitation services.[4] Because SNFs are reimbursed on a per diem payment system and lengths of stay appear to be significantly greater in SNFs—as opposed to rehabilitation hospitals and units—there is a real question as to the cost-effectiveness of treating these patients in SNFs, particularly when patient outcomes are difficult to compare across settings. These comparisons also fail to consider the downstream costs of less-than-optimal rehabilitation/functional status of patients, resulting in unnecessarily high dependency costs

[4] For the same reason, CPR also opposes raising the 60 Percent Rule to 75 percent. This, too, is a rule that ultimately serves to bar the door to the inpatient hospital or unit based solely on the diagnosis of the patient rather than one's individual medical and functional needs.

and perhaps unnecessary institutionalization in nursing homes rather than return to the home and community setting. In addition, the site-neutral proposal is premised on the supposition that these types of patients are equally served and have the same outcomes in both IRF and SNF settings. Recent data suggest otherwise.

In preliminary study results released in March 2014 by Dobson | DaVanzo,[5] Medicare data over a two-year period demonstrated that when patients are matched on demographic and clinical characteristics, rehabilitation provided in inpatient rehabilitation hospitals leads to lower mortality, fewer readmissions and emergency room visits, and more days at home—not in a PAC institutional setting—than rehabilitation provided in SNFs for the same condition. In terms of mortality, the starkest difference between the two settings involved patients with stroke, traumatic brain injury, and amputations. This study demonstrates that care provided in IRFs and SNFs is not the same and that outcomes are, in fact, significantly different as a result of the specific type of services provided in these two different settings. The study demonstrates the enduring effects of timely, intensive and coordinated rehabilitation provided in an IRF and how these services improve not only the length of beneficiaries' lives, but the quality of their lives as well. Rather than adopting this site-neutral proposal—and other more comprehensive PAC bundling proposals—Congress chose to exercise restraint and continue deliberating on this important set of policies. CPR applauds this Congressional approach solely based on the complexity of policies under consideration and the risks to patients if the reforms are not based on uniform, validated data and conceived with beneficiary protections in mind.

Bundling and Coordinating Post-Acute Care (BACPAC) Act of 2014

Congressman McKinley (R-WV) has released draft legislation to bundle post-acute care under the Medicare program. Known as the Bundling and Coordinating Post-Acute Care ("BACPAC") Act

[5] Assessment of Patient Outcomes of Rehabilitation Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge, Dobson, DaVanzo and Associates, Preliminary Report (March 2014).

of 2014, the bill seeks to bundle payments for Medicare post-acute care services (including SNF and extended care services, home health, inpatient rehabilitation hospital care, long term acute hospital care, durable medical equipment, and outpatient prescription drugs). A number of exceptions to the bundle are proposed such as physician services, hospice care, outpatient hospital services, ambulance services, and outpatient therapies. The bundled payment could be held by any entity that demonstrates the financial capacity to direct Medicare beneficiaries' PAC care including acute care hospitals, insurance companies and PAC providers.

CPR recognizes that the current "silos" of post-acute care can be inefficient and can discourage episode-based care that is patient centered. We favor well-developed bundling proposals based on sound evidence with fully developed quality measures and risk-adjusted payment systems so that savings are not achieved by stinting on patient care. Unfortunately, a bundled PAC payment system that includes these critical beneficiary protections does not exist and, we expect, will take several years to develop, adequately test, and validate. This is why, with certain caveats, we support existing bipartisan efforts to develop a uniform quality assessment instrument to measure outcomes across PAC settings.[6] Doing so is a critical step in both adopting appropriate—and sufficiently granular—quality metrics to ensure PAC patients under a bundled Medicare payment system achieve good patient outcomes and risk adjusters accurately capture the unique needs of individual patients.

Until these and other patient protections are in place, we do not support legislating broad PAC bundling reforms that lock-in federal savings and defer to the Secretary of the U.S. Department of Health and Human Services ("HHS") to implement a skeletal PAC bundling plan. It is simply too risky to Medicare beneficiaries to implement PAC bundling prematurely. In addition, there are a

[6] This draft legislation is known as the "IMPACT Act," or Improving Medicare Post-Acute Care Transformation Act of 2014.

number of improvements we would like to suggest to improve the draft BACPAC Act of 2014, including the following:

1. **PAC Bundle Holder**: We have serious concerns with the proposal to permit acute care hospitals and insurance companies to serve as the holder of the PAC bundle for the 90-day bundling period. Regardless of their ability to assume the risk, there are strong incentives in such a model for entities with little direct knowledge of rehabilitation to divert patients to the least costly PAC setting, as long as these patients are not readmitted to the acute care hospital, which comes with financial penalties. Current law requires CMS to pilot test a concept known as the Continuing Care Hospital ("CCH"),[7] where the PAC bundle would be held by this new PAC-centered entity which would provide a combination of post-acute care services currently provided by LTACHs, IRFs, and hospital-based SNFs. Any one of these three PAC entities or a combination of them could be the bundle holder. This concept would properly place the bundle in the hands of providers who understand rehabilitation and these patients' needs. In any event, the bundle holder MUST be accountable for the achievement of quality and outcome measures to protect against underservice.
2. **Entities Able to Assume the Risk**: Any bundle holder must be truly able to assume the risk of holding this bundled payment while providing services to a beneficiary across a 90-day episode of care. Financial solvency and related standards should be required by the legislation to ensure that bundle holders have the capacity to provide consistent and reliable care, even to outlier patients. Such standards ought to be tailored to PAC/rehabilitation providers, such as the standards of the Commission on Accreditation of Rehabilitation Facilities ("CARF") and other appropriate accreditors.

[7] Inexplicably, CMS has not yet pursued the mandated CCH pilot program.

3. **PAC Bundle Coordinator**: The draft BACPAC bill defines a "PAC Physician" as having primary responsibility with respect to supervising the delivery of the services during the PAC episode. We support a requirement that the person charged with making treatment decisions under the bundled payment be a health care professional rather than a layperson, and that this physician has experience in post-acute care/rehabilitation service delivery, as this is the very expertise necessary to develop and implement PAC treatment plans.

4. **Prosthetics, Orthotics and Custom DME Should Be Exempt from the Bundle**: CPR believes that certain devices and related services should be exempt from the bundled PAC payment system, just as outpatient rehabilitation therapy and other services are treated under the draft bill. For instance, customized devices that are relatively expensive and intended to be used by only one person should be separately billable to Medicare Part B during the 90-day bundled period. Prosthetic limbs and orthotic braces are critical to the health and full function of people with limb loss and other disabling conditions. Custom mobility devices[8] and Speech Generating Devices ("SGDs") serve the individual needs of very specific patients under the Medicare program. Under a bundled payment system, there are strong financial incentives to delay or deny access to these devices and related services until the bundle period lapses. Once this occurs, Medicare Part B would be available to cover the cost of these devices, but this delay is very deleterious to patient outcomes, and opportunities are lost for rehabilitation and training on the use of the device or technology during the PAC stay.

[8] Custom mobility devices are often referred to as "Complex Rehabilitative Technology" or "CRT." In fact, bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, "Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013," H.R. 942 and S. 948.

This phenomenon was witnessed when Congress implemented prospective payment for SNFs in 1997 and initially included orthotics and prosthetics in the SNF bundle or Prospective Payment System ("PPS.")[9] As a result, most SNFs began to delay and deny access to prosthetic and orthotic care until the beneficiary was discharged from the SNF and then Medicare Part B assumed the cost of orthotic and prosthetic ("O&P") treatment. During this period, SNF patients experienced inappropriate and unreasonable delays in access to O&P care. Such delays and denials of O&P care often impede patients' ability to independently function or, in some cases, result in life in a nursing home. In 1999, Congress recognized this problem and exempted a large number of prosthetic limb codes from the SNF PPS consolidated billing requirement,[10] thereby permitting these charges to be passed through to Medicare Part B during the SNF stay.[11] As a result, SNF patients once again had access to prosthetic limb care during the course of their SNF stay. This experience should not be repeated under new bundled payment systems and, therefore, we recommend that Congress exempt prosthetics, custom orthotics, and custom durable medical equipment from any PAC bundling legislation.

5. **Exemption of Certain Vulnerable Patients from First Phase of Bundling**: PAC bundling is a concept that is clearly untested at this time and, while CPR does not oppose the concept, we strongly believe that safeguards must be included in any PAC bundling legislation to protect vulnerable Medicare beneficiaries. Among these Medicare patients are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes,

[9] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 –22 (1997) (codified at 42 U.S.C § 1395yy).
[10] Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, § 103, 113 Stat. 1501A-321, 1501A-325–26 (1999) (codified at 42 U.S.C § 1395yy(e)).
[11] Unfortunately, Congress did not similarly exempt custom orthotics from the SNF consolidated billing requirements which has led to a serious lack of access to appropriate custom orthotic care in the SNF setting.

multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they are very important and very vulnerable subgroups that, we believe, should be exempt from the first phases of any bundled payment system. While such groups of patients could be phased-in at the patient's option as bundling develops, we believe the most vulnerable patients should only be included in PAC bundling on a mandatory basis when the bundled payment systems can demonstrate sufficient quality outcomes, risk adjusters, and patient safeguards to ensure quality care.

6. **Appropriate PAC Quality and Outcome Measures**: Quality measures must be mandated in any PAC bundling bill to assess whether patients have proper access to necessary care. This is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various PAC settings do not currently exist. The existing LTCH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care. For instance, before widespread PAC bundling is adopted, measures must be incorporated into the PAC system that cover the following domains:

- Function: Incorporate and require the use of measures and measurement tools focused on functional outcomes that include measurement of maintenance and the prevention of deterioration of function, not just improvement of function;
- Quality of Life: Require the use of quality of life outcomes (measures that assess a return to life roles and activities, return to work if appropriate, reintegration in community living, level of independence, social interaction, etc.);[12]
- Individual Performance: Measurement tools should be linked to quality outcomes that maximize individual performance, not recovery/rehabilitation geared toward the "average" patient;
- Access and Choice: Measures should include assessment of whether the patient has appropriate access to the right setting of care at the right time and whether the patient is able to exercise meaningful choice; and,
- Patient Satisfaction: Measures should not be confined to provider-administered measures but should directly assess patient satisfaction and self-assessment of outcomes. CMS or MedPAC should be required to contract with a non-profit entity to conduct studies in this area and factor the results into any final PAC bundled payment system in the future.[13]

7. **Create Financial Disincentives to Divert Patients to Less Intensive Settings**: In order to protect against diversion of patients to less intensive, inappropriate PAC settings, we recommend that any PAC bundling legislation include instructions to the HHS Secretary

[12] These extended functional assessment and quality of life measures are consistent with the World Health Organization's International Classification of Functioning, Disability and Health and the measurement tool designed around the WHO-ICF known as the Activity Measure for Post-Acute Care™ ("AM-PAC"™).

[13] "uSPEQ" (pronounced "You Speak") is an example of a patient satisfaction assessment tool that measures the end users experience with their post-acute care experience. The survey can be answered by the patient, family or caregiver.

that payment penalties should be established to dissuade PAC bundle-holders from underserving patients.

Thank you for the opportunity to testify on this important issue area. The CPR Coalition is ready and willing to assist this Subcommittee as it continues to consider site-neutral payments and bundling proposals under the Medicare program.