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Senate Finance Committee Roundtable on Healthcare Delivery System Reform
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Kindred Healthcare is pleased to submit these comments in advance of the Senate Finance Committee's Roundtable on April 21, 2009. As the nation's largest provider of post-acute care, Kindred is honored to participate in the Roundtable on delivery system reform. We commend the Chairman and the entire Committee for soliciting the input of various stakeholders as Congress considers different approaches to healthcare reform. In 2008, Kindred's 53,700 employees provided care to over 32,000 patients and residents in our Nursing and Rehabilitation Centers, 28,000 patients in our Long Term Acute Care Hospitals, and 115,000 patients receiving rehabilitation services. We also are expanding our offerings in assisted living, homecare and hospice services. We care for the most chronically ill, medically complex Medicare and Medicaid beneficiaries who are the highest users of resources in our healthcare system. We partner with public and private payers to deliver cost-effective services and have the perspective of operating under a range of service delivery models.

While my comments will focus primarily on issues concerning post-acute care, I wanted briefly to share my perspective on broader healthcare reform and delivery system design.

First, as a provider of diversified post-acute care services and an employer providing health insurance coverage to our workers in over 40 states, we support Congress' and the President's efforts to enact comprehensive healthcare reform. The first priority for healthcare reform should be to ensure that every American has adequate health insurance coverage. We also share the President's and Chairman's commitment to contain healthcare cost growth, both to preserve a sustainable healthcare system and also to facilitate economic recovery. At the same time, policy measures to stem the growth in healthcare costs should be targeted so as to minimize disruption to the system, preserve jobs, prevent unintended access and quality problems, and be implemented in such a way as to promote progressive reform of the payment and delivery systems.

Second, healthcare reform should be guided by the overriding principle that our healthcare delivery should be patient-centered. An integral attribute of a patient-centered system is active engagement of physicians in overseeing care delivery and nurses facilitating better care coordination. Healthcare reform on the one hand should address barriers to patient-centered care such as defensive and volume-based care practices, and on the other hand actively support key enablers such as adoption of health information technology and dissemination of proven evidence-based healthcare practices.

Third, we commend the Administration and the Chairman for including the coordination of post-acute care services as part of the healthcare reform discussion. Kindred supports expanding this discussion to include long-term and post-acute care reform as an integral part of comprehensive healthcare reform. The reality is that a growing number of Medicare beneficiaries with multiple chronic conditions account for a disproportionate percentage of healthcare spending. This compels the conclusion that healthcare reform should not ignore long-term and post-acute care.

Fourth, Kindred supports the policy goals of improving post-acute care coordination and increasing efficiency in payments in the post-acute care delivery system. The Medicare payment and care delivery systems too often operate in silos, resulting in a lack of needed care coordination and inefficiencies in payments. A silo approach can contribute to unnecessary re-hospitalizations, poor quality, payment redundancies, and higher than necessary costs. These are important and legitimate policy issues that should be addressed by policymakers, payers and providers through a variety of approaches.

One approach being considered by policymakers is "bundling" of post-acute payments. The President's budget contains a proposal to "bundle" payments to post-acute providers into a single payment to the acute care hospital. Under this proposal, the acute care hospital would be responsible for all costs and care coordination for Medicare beneficiaries following hospital discharge. While Kindred agrees that the policy issues a bundling policy seeks to address are important, we urge policymakers to adopt an incremental approach. Bundling should be just one of several policy approaches that should be evaluated and carefully considered before major system redesign is implemented. As noted by MedPAC, bundling could produce unintended consequences, so Kindred supports an incremental approach through use of pilots and/or demonstration projects. Because of our diverse post-acute service lines and experience with a range of care delivery models, Kindred is well situated to help policymakers develop approaches that promote quality care and efficient payments. Based on our experiences with public and private payers, Kindred encourages the Committee to consider the following issues when evaluating the bundling policy, or other approaches to improving care coordination and promoting efficiency in Medicare's post-acute payment systems.

Important threshold issues should be considered and tested before implementing a bundling policy.

One threshold issue policymakers should evaluate is whether entities other than acute care hospitals should be considered as viable options to manage a bundled payment and coordinate care. While a limited number of integrated health systems may be in a position to implement bundling, the reality is that many acute hospitals, especially in rural areas, lack the infrastructure to coordinate post-hospital care for chronically ill patients because their mission is to stabilize and treat acute conditions, then move patients downstream as quickly as possible. Changing payment incentives alone will not

address the infrastructure and system investments needed to effectively coordinate post-hospital care.

An increasing body of research suggests that enabling community-based physicians through appropriate incentives to serve as "medical homes" for certain chronically ill patients should be considered as a policy alternative, or supplement to, bundling. For example, researchers at Johns Hopkins School of Public Health, Roger C. Lipitz Center for Integrated Health Care, have tested a "guided care" model for chronically ill patients. Under this model, community-based physicians with the support of trained nurses and health information technology implemented a range of "guided," or coordinated care approaches that yielded substantial cost savings and quality gains. Specifically, this guided care approach not only covered its own costs but also reduced insurance expenditures by $1,600 per patient per year.1

Finally, notwithstanding other concerns, many managed care and other organizations (e.g., PACE entities) have the infrastructure to coordinate care for chronically ill Medicare beneficiaries. In fact, these entities already function in a type of "bundled" world. Kindred has worked with various entities involved in coordinating post-acute care, ranging from fully integrated systems such as Kaiser, to specialty programs such as "EverCare," to other payers who partner with us to help manage patients throughout our various post-acute service offerings. The shared goal in these partnerships is to coordinate patient care by identifying the most cost-effective setting that is able to deliver quality care. The ultimate goal is to facilitate patients' return to home as soon as possible, without experiencing hospital readmissions. In fact, in Kindred's nursing and rehabilitation centers, nearly half of our patients are able to return home in about 30 days after admission. A key component to achieving this result and effectively manage this transition in care is that these patients have access to home health and community-based care, a critical part of the post-acute care delivery system. These service delivery models should be evaluated by policymakers as alternatives to, or complements of, a bundled payment policy.

Important prerequisites in the payment and care delivery systems should be addressed incrementally before implementing full-scale bundling or similar approaches.

Public and private sector entities are currently engaged in a variety of activities that are testing approaches to coordinated care that will serve as important building blocks to support a bundling policy. Specifically, there are several existing policy activities that are midstream in addressing some of the prerequisites that are needed before implementing bundling in different forms. These activities should not be overlooked or abandoned by policymakers by implementing bundling too quickly.

[1] Boult, Chad, Rider, Lisa, Frey, Katherine, et al. "Early Effects of 'Guided Care' on the Quality of Health Care for Multimorbid Older Persons: A Cluster-Randomized Controlled Trial." Journal of Gerontology: Medical Services. Vol. 63A, No. 3, (2008): 321-327

1. ***Patient Criteria and Appropriate Patient Placement***. Objective tools are needed to help determine how to place patients in the most appropriate care setting based on their needs and the probability of producing quality outcomes. At the direction of Congress, CMS has contracted with the Research Triangle Institute (RTI) to develop a Uniform Patient Assessment Instrument as part of a large-scale demonstration project involving the range of post-acute providers, including Long Term Acute Care Hospitals, Inpatient Rehab Facilities, Skilled Nursing and Rehab Facilities and Home Health providers. Without the tools to determine which settings are most appropriate for chronically ill Medicare beneficiaries, a bundled payment approach can produce some of the unintended consequences noted by MedPAC such as poor quality and, for certain patients, higher episodic costs.

2. ***Facility Criteria to Ensure Quality Care***. In addition, mechanisms are needed to ensure that facilities have the requisite capabilities to care for patients with different needs. For example, as recommended by MedPAC, Long Term Acute Care Hospitals should have certification criteria, first to ensure that only those patients who need LTAC care are admitted and next to ensure that facilities holding themselves out as having the capacity to treat medically complex patients have invested in the infrastructure, staffing, and physician support to provide quality care. Facility criteria can help address one possible unintended consequence of bundling or any "capitated" payment approach, namely, patients being inappropriately placed in care settings that are low cost but not equipped to meet patient needs.

3. ***Alignment of Payment with Patient Characteristics***. Payment policies must align reimbursement levels, including outlier adjustments, with patient needs and characteristics. The goal is that the payment system should support quality care in the lowest cost setting. In post-acute care, more evidence-based research is needed to understand which settings are capable of treating chronically ill patients with different characteristics to produce desirable outcomes. For example, as noted above, Kindred and other nursing and rehabilitative care centers are able to transition a large percentage of people into their homes. How does this result compare with other provider types, for what types of patients and at what cost? Which patients are susceptible to re-hospitalization if moved too quickly to lower cost settings? This type of comparative effectiveness research is needed to help shape and implement a bundling policy, including being able to calculate episodic payment levels to produce desirable quality outcomes.

4. ***Transparency, Comparative Effectiveness, and Development of Post-Acute Quality Measures that are Common Across Sites of Service***. As noted by MedPAC, providers, payers and regulators need adequate information in order to effectively coordinate care between settings to achieve quality improvements and cost savings. Likewise, consumers need access to understandable information to be part of care decision-making. In post-acute care, it is vital to have quality measures that transcend sites of care and for there to be a high level of

transparency on these performance measures. Currently, the post-acute space lacks a common set of quality indicators to evaluate care outcomes as patients move across sites of service. Without a common set of quality indicators, it is difficult to evaluate the comparative effectiveness of different post-acute providers for certain patients.

Unfortunately, the comparative effectiveness literature is especially thin when it comes to chronically ill patients. A recent New York Times article reported that because so little research includes chronically ill patients, physicians have little scientific evidence on which to base their care.[2] A 2005 study found that fewer than half of evidence-based clinical practice guidelines used to treat nine of the most common chronic diseases specifically addressed patients with multiple illnesses. And a 2007 study found that 81 percent of the randomized trials published in the most prestigious medical journals excluded patients because of coexisting medical problems. Being able to compare quality performance and cost-effectiveness across post-acute sites of care is critically important under any kind of bundled payment system, both to ensure quality and also to enable providers to effectively coordinate care and manage transitions.

5. ***Health Information Technology as a Key Enabler of Care Coordination***. Many experts have observed that to manage transitions in care effectively requires a certain level of investment in health information technology. While many post-acute providers, including Kindred, have begun making these investments, the reality in many parts of the country is that the level of health information technology infrastructure is thin. Unfortunately, only a tiny portion of the billions of dollars available for health information technology in the Stimulus Package is available to post-acute providers, so the investment in HIT for this sector will lag other healthcare sectors.

6. ***Review and Revision of Existing Regulatory Requirements***. A variety of existing regulations would need to be reviewed and possibly revised before proceeding with bundling. These include: 1) 3-day prior hospital stay requirement before Medicare pays for post-acute care; 2) various LTAC regulations such as the 25-day length of stay requirement, "25% rule" restricting patient referrals, and others that are inconsistent with integrated care delivery and payment; 3) IRF "60 percent" rule; 4) various state Certificate of Need and licensure regulations; and 5) Stark physician referral regulations and prohibitions.

Policy approaches in addition to bundling should be tested and evaluated through demonstration projects and/or pilots.

Kindred encourages Congress to evaluate the feasibility and desirability of bundling and similar policies through demonstration projects and pilots. We also urge

[2] Carpenter, Siri. "Treating an Illness Is One Thing. What About A Patient With Many?" The New York Times 31 March 2009:

Congress to maintain a strong oversight role specifically by requiring CMS to report the results of bundling-related demonstrations and pilots so that Congress retains the responsibility to craft legislation based on objective evidence and stakeholder input. We acknowledge that demonstration projects can take time and that the magnitude of our policy problems require expeditious attention. At the same time, Congress should balance the need to move expeditiously on policies proven to be comparatively effective with the prudence advocated by MedPAC of incrementally testing different approaches to avoid system disruption and unintended consequences. Congress can achieve this balance by requiring frequent reports on demonstrations and pilots. Where proven effective, Congress can then move quickly on policies in the short-term that are consistent with comprehensive reform in the long-term. In addition to bundling, Congress should actively evaluate the following alternatives.

1. ***Site Neutral Payment***. CMS is midstream in an important demonstration project to develop and test a uniform post-acute assessment instrument. Kindred nursing and rehab facilities and LTACs have participated in this project at all stages, from initial tool development, to I-S system development, to testing the instrument. The development of an assessment instrument is an important prerequisite to placing patients in the most appropriate clinical setting, identifying their care needs, aligning payment with those needs, and ultimately developing a "site neutral" payment system. The report to Congress on this demonstration project will provide valuable information to policymakers regarding whether a site neutral approach, as an alternative or supplement to a bundled payment approach, is the best solution for Medicare. Congress should support complementary demonstrations and pilots related to bundling.

2. ***"Medical Homes" for Chronically Ill Patients through Physician-Coordinated Care***. As noted above, there is a growing body of research, including at Johns Hopkins University, on physician directed and nurse supported models of coordinated care and "medical homes." Congress and policymakers should carefully evaluate the effectiveness and characteristics of these various approaches as part of its work to improve care coordination and payment efficiency. These approaches are not necessarily inconsistent with a bundled payment approach, but they should also be considered as a possible alternative.

   It is very important for Congress to evaluate approaches such as physician and nurse "guided care," especially as compared to other approaches that have not proven to be effective. A recent analysis in the Journal of the American Medical Association of 15 randomized trials testing different models of "coordinated care" for Medicare beneficiaries found that "none of the 15 programs generated net savings" to Medicare.[3] The researchers' core conclusion is very instructive as Congress evaluates the effectiveness of different bundled payment approaches: "Viable care coordination programs without a strong transitional care component

[3] Peikes, Deborah; Chen, Arnold, Schore, Jennifer, et al. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." 2009 American Medical Association. (Reprinted) JAMA Vol. 301, No. 6 (February 11, 2009): 603-618.

are unlikely to yield net Medicare savings. Programs with substantial in-person contact that target moderate to severe patients can be cost-neutral and improve some aspects of care." This type of "comparative effectiveness" research is important to consider before implementing a full-scale bundling policy.

3. ***CMS "Care Transitions Program" Pilot to Improve Quality As Patients Move Across Care Settings***. Just three days ago CMS announced an important pilot project pursuant to which 14 communities throughout the United States have been funded to reduce rates of hospital re-admissions and improve "fragmentation of care" in Medicare. Under this pilot, local Quality Improvement Organizations are charged with mobilizing local communities and providers to "refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high value healthcare they deserve." [4] The results of this pilot will provide Congress with valuable information about how to structure the care delivery and payment system to produce the outcomes that are sought to be achieved by a bundling policy. It is important to get this type of information before implementing full-scale bundling.

4. ***ACE Demonstration Project***. CMS also recently embarked on the "Acute Care Episode" (ACE) demonstration project. The stated goal of the ACE demonstration project is to use a global payment to better align the incentives for both hospitals and physicians leading to better quality and greater efficiency in care. According to CMS, the ACE demonstration project will also test the effect that transparent price and quality information has on beneficiary choice and provider referrals for select inpatient care. This demonstration will provide Congress with useful information about the effectiveness and unintended consequences of different bundling or episodic approaches to care delivery.

5. ***Policymakers Should Consider Comprehensive Reform Proposals for the Post-Acute and Long-Term Care System***. The Alliance for Quality Nursing Home Care and The American Healthcare Association, of which Kindred is a member, will shortly release a comprehensive long-term care reform proposal that improves access, expands consumer choice, promotes care coordination, and achieves substantial savings. I look forward to sharing this proposal with the Committee as one option to advance healthcare and long-term care policy.

Policymakers should avoid adopting short-term, budget-driven policies that are inconsistent with the goal of improving post-acute care coordination and payment efficiency.

Policymakers should not perpetuate the disjointed nature of the current payment and service delivery systems by enacting silo-based policies that would inhibit progress towards improving the post-acute care service delivery and payment system. In a recent article on "episodic" payments, the authors caution: "Before provider payments are reduced, our payment system must be reformed to encourage the more efficient delivery

[4] "Medicare Announces Sites for Pilot Program to Improve Quality as Patients Move Across Care Settings." April 13, 2009. www.cfmc.org/caretransitions.

of care…so that new delivery models can gain traction."[5] There are several examples of short-term payment policies currently under consideration that could perpetuate our silo system and interfere with post-acute rationalization. The following examples are not meant to be exhaustive and Kindred urges policymakers to evaluate short-term policies for all Medicare and post-acute providers given the interconnectedness of the healthcare delivery system from the patients' perspective.

1. ***Various Pending Policies Related to SNFs***

"Forecast Error": Payments to Skilled Nursing Facilities may be reduced on grounds that original forecasts of Medicare expenditures underestimated the numbers of patients that would seek and receive more intensive rehab and medically complex services in SNFs. This proposed adjustment would be inconsistent with one goal sought by the bundled payment approach, i.e., to facilitate placement of patients in the lowest cost, quality setting. In this case, SNFs have invested heavily into increasing capabilities to admit, treat and return to home a growing number of patients requiring intensive rehabilitative care and care for patients with multiple chronic illnesses. The growing number of patients seeking care in SNFs is largely a result of policies that have shifted patients to lower cost settings such as SNFs. Implementing the forecast error payment reduction would inhibit continued investments in cost-effective care that serves as an incremental step towards bundling, site neutral payment, or other post-acute rationalization policies.

RUGs Refinement and STRIVE: Likewise, possible revisions to the Medicare RUGs payment system could limit the ability of SNFs to continue making the investments to provide quality medically complex and rehab intensive care in a cost-effective setting. While Kindred supports improvements in payment systems, the practical effect of these changes could be inconsistent with the overall goal of supporting access to quality care in the least costly setting.

Linkages between Medicare and Medicaid for Dually Eligible Beneficiaries: Even with the successful passage of the Stimulus Bill that provided relief to states for Medicaid expenditures, many states are still cutting provider payment rates in these economic times. Reductions in SNF Medicare payments should also be evaluated in the larger context of overall funding adequacy for SNFs. While Medicaid and Medicare funding are often viewed as distinct policy silos, SNFs providing care to individuals at the bedside cannot so distinguish between sources of funding especially for dually eligible beneficiaries. Instead, overall payment adequacy for SNFs—from all public and private sources—enables SNFs to structure operations and hire staff to meet the needs of patients and residents. The reality today is that overall SNF margins are the lowest of any provider type, hovering just above zero because

[5] Mechanic, Robert E.; Altman, Stuart H. "Payment Reform Options: Episode Payment is a Good Place to Start." Health Affairs – Web Exclusive (2009): 262-271.

Medicaid pays nursing homes well below cost. Today, Medicare literally props up the long term care delivery system by paying rates that cross-subsidize inadequate Medicaid payments. As we seek to pursue a rational long-term care system, the adequacy of payments from all sources should be the benchmark against which the reasonableness of any specific policy proposal is evaluated.

2. ***LTAC Certification Criteria***. The LTAC provider community has strongly supported MedPAC's recommendation to implement expeditiously "certification criteria" to ensure that only medically complex patients are admitted to LTACs and to advance the goal of aligning payments to LTACs with patient characteristics. Expeditious implementation of LTAC certification criteria supports incremental progress towards post-acute bundling, site neutral payment or other policies that seek to advance the dual goals of coordinated care and payment efficiency. It does so by: 1) facilitating appropriate patient placement and ensuring that only those who need LTAC care are admitted; 2) defines requisite facility criteria to ensure that facilities are capable of meeting the needs of a medically complex patient population; and 3) through the existing LTAC prospective payment system aligns payments with patient characteristics. As noted above, these are all prerequisite steps towards implementing a bundled or site neutral payment system.

On behalf of Kindred, I would like to thank the Chairman again for the opportunity to share our perspective on healthcare reform and the design of the care delivery system. We support the President's and Congress' commitment to pursue comprehensive healthcare reform and the primary goal of providing every American with healthcare coverage. We also recognize the rate of growth in healthcare costs is unsustainable. We appreciate the inclusion of post-acute care in the healthcare reform discussion and hope that some of the ideas we shared today can help contribute to improvements in our delivery system and containment of costs through better care coordination for chronically ill people, greater efficiencies in payment, and short-term reductions in cost through reduced hospitalizations and gains in quality. We stand ready to assist the President, the Chairman, members of this Committee and Congress to advance progressive healthcare and post-acute policy.