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Senate Finance Committee Hearing
Progress in Health Care Delivery: Innovations from the Field
Washington, D.C.
May 23, 2012

Kindred Healthcare is pleased to submit these comments for the Senate Finance Committee's hearing on "Progress in Health Care Delivery: Innovations from the Field." Kindred is honored to participate in the hearing and share our experiences about the critical role that post-acute care plays in transforming our delivery system into one that is more patient-centered, outcome-driven and integrated. In particular, we commend the Chairman, the Ranking Member and the entire Committee for seeking input from those of us in the field who are testing new models to improve care and reduce costs through the many collaborative innovations in care delivery.

The Committee's decision to hold this hearing on delivery system reform is very timely. Hospitals, health systems, managed care organizations, physician groups, post-acute providers and others across the country are actively engaged in efforts to transform our nation's healthcare system through private sector and publicly supported initiatives. There is a growing recognition that our current healthcare delivery system must be changed. Kindred has a national vantage point to offer in these discussions since we operate in over 40 states and are participating in a range of reform efforts in local healthcare communities throughout the country. As a provider of diversified post-acute services caring for our nation's sickest and most expensive patients, Kindred is actively working with private and public Accountable Care Organizations (ACOs), hospitals, health systems, physicians and managed care organizations on innovative ways to deliver integrated care, improve quality, restore wellness and reduce costs.

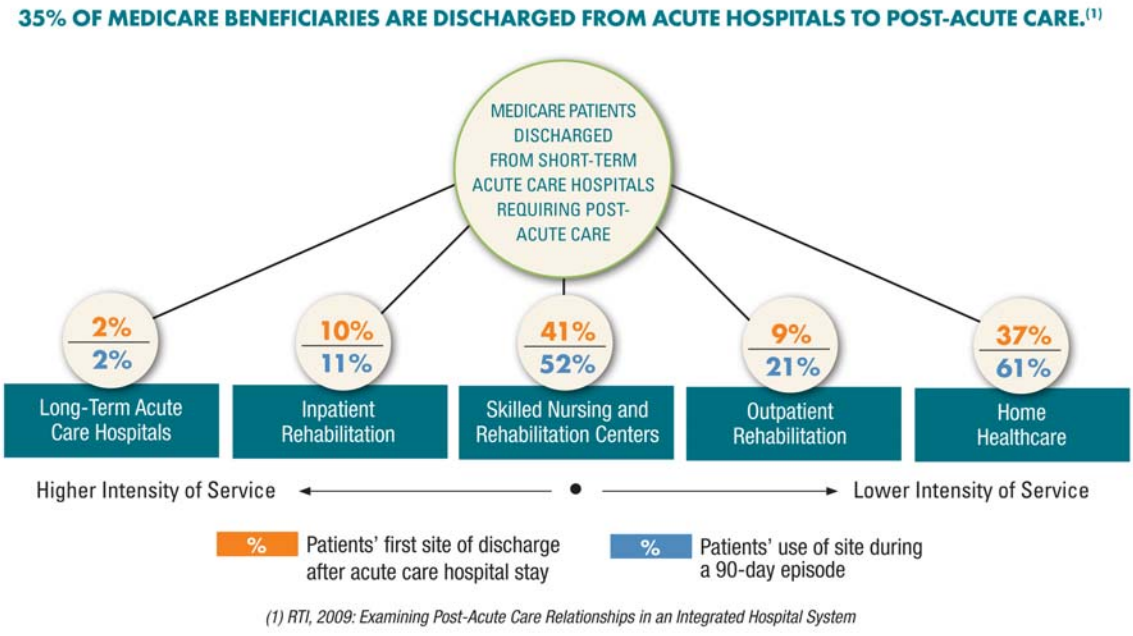
At the outset I want to emphasize that transforming our healthcare system requires building trust, collaboration, cooperation and aligned incentives between providers, payers, patients, and policymakers. It won't be easy, and in our experience systemic change will require incremental reforms, but without a culture of cooperation, teamwork and trust between those charged with delivering and paying for care, I fear we will remain stuck in our current silos, state of inefficiency and unsustainable cost growth. I will emphasize this theme throughout my comments.

Why is Care Delivery Reform Needed and Why is Post-Acute Care Important?

Before sharing with the Committee some examples of new care delivery models we are testing with our partners in the field, I would like to provide some context as to why we are engaged in these activities and why post-acute care is so important to delivery system reform.

As you know, the existing fee-for-service system, which pays for volume rather than value, has produced a fragmented delivery model that does not serve patients well and contributes to unsustainable cost growth. This problem also exists in "post-acute" care, where a growing number of chronically ill and medically complex patients require care after a short hospital stay. Today, there are over 47 million Medicare beneficiaries and an estimated 7,000 individuals added to the program every day.[1] A growing number of these people have chronic conditions such as diabetes and heart disease and represent the most expensive patients to care for as they cycle through our system with acute care hospitalizations, re-hospitalizations, and consumption of other health care services. The following chart from a CMS-sponsored study illustrates this point and also highlights the critical role that post-acute care can play in coordinating care and lowering healthcare costs: 35% of all Medicare beneficiaries who have been admitted to an acute care hospital require some form of post-acute care following their hospital stay. These same patients often require care in more than one post-acute setting to meet their needs.

Tremendous Opportunities Exist to Better Manage Patient Care for Patients Discharged From Acute Care Hospitals



The problem from a care perspective is that as patients move from the acute care hospital to multiple post-acute settings there isn't anyone, particularly physicians, who are responsible for coordinating care and driving the outcomes throughout the patient's entire episode. This results in a lack of coordination among providers, confusion about how to transition patients, when to transition, what is the most appropriate setting and how to continue the care in a seamless way from provider to provider. This "silo-based" delivery system does not make the most efficient use of healthcare services based on individual patient need. Worse, it is not "patient-centered" in terms of achieving the

[1] Kaiser Family Foundation, 2011 and AARP 2011 projections

patient's goal of getting well and home more quickly. And it results in fragmented care including unnecessary hospitalizations, a major focus of policymakers and providers.

This system is also not ideal from a payment perspective. Because providers are paid each time the patient has an encounter with the healthcare system, there is little incentive for coordination of care and this system can produce redundancy in services and higher than necessary costs.

The Need for Coordinated, Cost-Effective Post-Acute Care

Several years ago Kindred as well as many other post-acute providers embarked upon an effort to develop the capabilities to meet the needs of patients throughout their entire episode of post-acute care-- from hospital to home-- to begin to address the shortcomings of the silo-based system described above. The goal is to become a post-acute "continuum of care" provider so that we can be part of the solution for patients and payers in a future healthcare system that will be more integrated. As I noted at the beginning of my comments, this is not a goal that post-acute providers can achieve on our own. Instead, we are working with acute hospitals, health systems, managed care organizations, physicians, care managers and others to "integrate" post-acute care into the broader healthcare delivery system to achieve our shared goals. Our motivation for doing so was well summarized by MedPAC in their 2007 Report to Congress: "Effective coordination of care between acute and post-acute settings has benefits for patients and providers. Such coordination can reduce hospital readmissions—thereby reducing spending and improving patient experiences."

Today, Kindred is the largest provider of diversified post-acute care in the nation, operating in over 40 states. Within these 40 states we are focused on approximately 20 local healthcare communities where we are building the capacity to develop the service lines that span the entire post-acute spectrum so that we can partner with others in the delivery system to better coordinate care. We have 121 Long Term Acute Care Hospitals (LTACs) serving the most critically ill patients, 5 free-standing and 102 hospital-based Inpatient Rehabilitation Facilities (IRFs) providing intensive rehabilitation services to restore functional ability, 224 Skilled Nursing and Rehabilitation Centers (SNFs) providing restorative, rehabilitative and long term care services, and 51 Home Health and Hospice sites providing in-home services and palliative hospice care. We are also the largest provider of rehabilitation services in the nation, with 2,100 sites of service providing physical, speech, and occupational therapy to about 500,000 patients a year.

But our size and national scale is less important than our efforts to be able to provide a continuum of post-acute care in local healthcare communities. The following map shows Kindred's sites of service throughout the country and highlights those communities where we have or are developing the capacity to deliver a continuum of integrated post-acute care.

Advancing Integrated Care: Kindred is developing the capacity to deliver the full continuum of post-acute care in local healthcare markets

Innovations in the Field: Key Capabilities Needed to Provide Integrated Acute and Post-Acute Care

Kindred's growing capacity to deliver the continuum of post-acute care in local communities has provided us with a good opportunity to test different models of integrated care with our hospital and managed care partners to improve quality and reduce costs. We have discovered in testing these models that no one approach will fit every situation and every community. The adage that "all health care is local" is especially true when considering how to transform the system and make care and payment more integrated. Still, we have learned that there are certain key capabilities that are needed to integrate care across a patient episode, and we have focused on these key capabilities in our new care model pilots.

Clinical Integration Between Acute and Post-Acute Care, and Between Post-acute Providers

As I noted earlier, trust and collaboration among a team of physicians, nurses, therapists, and other post-acute and acute providers is crucial to reforming our delivery system. We have learned that a critical first step is to achieve clinical integration with our hospitals and managed care organizations. We do this through establishing "Joint Operating Committees" (JOCs) with our partners to establish a formal mechanism to identify shared goals and strategies to coordinate and improve quality care. These JOCs have a formal charter, include clinical, care management and operational representatives from each of our organizations, meet regularly and use structured agendas to identify specific clinical outcome, patient satisfaction and efficiency goals, and collect and analyze data to measure progress and identify areas for improvement.

Kindred has established dozens of JOCs throughout the country with hospitals, health systems, physicians, managed care payers, and private and public ACOs. This type of clinical integration can yield significant and immediate results even under the current fee-for-service payment system: As a result of our efforts in collaboration with our acute hospital partners, Kindred has reduced re-hospitalization rates by over 8% in our LTACs and Skilled Nursing and Rehabilitation Centers since 2008.

A specific case study can demonstrate the power of collaboration and communication to improve quality and reduce costs immediately. A Joint Operating Committee between Kindred and a prestigious Academic Medical Center in Cleveland, Ohio focused on higher than acceptable re-hospitalization rates. The Joint Operating Committee analyzed the data and found that a significant number of re-hospitalizations from Kindred post-acute settings involved patients with urinary tract infections ("UTI"). To examine the issue further, patients were screened prior to post-acute admission and it was discovered that many patients had actually acquired the UTI in the acute care hospital, prior to post-acute admission, but before clinical symptoms had appeared. The intervention chosen was to more actively screen and treat patients prior to discharge from the acute care hospital. The result was a significant decrease in re-hospitalization rates.

We have achieved similar declines in re-hospitalization rates with Managed Care Organization ("MCO") partners, but MCOs are also interested in reducing lengths of stay over episodes of care since they are paid on the basis of capitation. A Joint Operating Committee with a Physician-led managed care organization in Las Vegas, Nevada has focused on appropriate length of stay for the multiple Kindred post-acute service lines in that market—LTAC, hospital-based subacute, and free-standing skilled nursing and rehabilitation services. Based on appropriate use of each of these services lines, and a relentless focus on appropriate length of stay across an episode of care, post-acute length of stay has been significantly reduced. Kindred and other acute and post-acute providers have achieved similar results nationwide: Between 2008 and 2011 patient length of stay has dropped at Kindred LTACs and Skilled Nursing and Rehabilitation Centers by 12% and 27% respectively. This is better for patients as they are able to return home sooner and it also lowers cost to the system by reducing length of stay.

Physician Participation in Care Management Across Settings

A very important part of achieving care integration across settings is the role of physicians in participating in decision-making and overseeing care across multiple service sites. Under the current fragmented system, physicians typically oversee patient care *within* settings, but rarely follow patients from acute, to post-acute, to home to make sure that the care is coordinated and seamless *across* settings. The movement towards "medical homes" and other arrangements to engage physicians in population health management are encouraging, but we have found that more is needed in the short-term to better coordinate post-acute care.

The models of physician care oversight vary significantly from community to community. As a result, Kindred and our partners are testing a range of models to achieve the goal of active physician engagement in care management across an episode of care. In Indianapolis, where Kindred has the full range of post-acute services, we are working with a large health system who has been selected as a "Pioneer ACO." We also have an affiliation with an independent physician practice group whose practice privileges include the acute hospital system as well as Kindred's post-acute service offerings. Our coordination with both the hospital system and the physician group enables treating physicians to follow their patients throughout an entire episode of care. This increases the likelihood of care being better coordinated and also reduces the risk of re-hospitalization.

In Denver and other markets, the absence of an independent physician practice group with the capacity to follow patients from acute to post-acute sites requires a different approach. In these markets, we are testing a "Hospitalist" model in affiliation with a national organization that provides Hospitalist services to both acute and post-acute providers. Under this approach, we have identified Hospitalists who treat patients in acute care hospitals and are willing to follow those patients into Kindred post-acute settings to ensure smooth transitions in care and to better integrate care across settings.

In a growing number of markets across the country it is increasingly common for physicians to become employed by hospitals, health systems, and managed care payers. In fact, over 50% of physicians are now employed by hospitals and a decreasing number are choosing independent practice. The challenge for post-acute care providers is the availability of enough physicians to provide care, particularly integrated care across our sites of service. To respond to this trend, in markets such as Cleveland where most physicians are employed by hospitals, we have established an agreement with the hospital system to have hospital-employed physicians follow their patients into our post-acute settings. The example given above about the reduction of re-hospitalizations attributable to urinary tract infections was made possible because staff physicians from the acute hospital system not only follow their patients to Kindred post-acute sites of care, but also actively participate in our Joint Operating Committee.

The Importance of Information Technology, Electronic Health Records and Interoperability as a Key Enabler for Care Integration

In addition to clinical integration and physician coverage across sites of care, a key enabler for care integration is the availability of Electronic Health Records and information technology. The ability to collect and retrieve patient information accurately and efficiently *within* healthcare settings can improve quality care and reduce costs. The ability to transmit this information *across* sites of care is a critical element to effective care management over an episode of care.

While few providers across the country have achieved full adoption of electronic health records, there is some progress being made and Kindred is piloting different approaches. We have a Kindred-specific 5-year I-T plan, costing millions of dollars, to install health information technology within each of our service lines and currently have an electronic health record in our LTACs. At the same time that we are working on installing electronic health records within Kindred service lines, we are also testing ways to create "interoperability" with our acute care partners.

In Cleveland, for example, we have established an I-T linkage between the EPIC Electronic Health Record system used by our acute hospital system partner and our own LTAC electronic health record. This enables physician access to electronic patient records in both settings and includes information from both the acute hospital and post-acute stay. We are in the process of creating a similar linkage with the records in our hospital-based sub-acute service line as well as our free-standing Skilled Nursing and Rehabilitation facility. This interoperability has produced a high level of physician and patient satisfaction, enabled improved integration of care, and in the future will be a key enabler to support a more integrated delivery system.

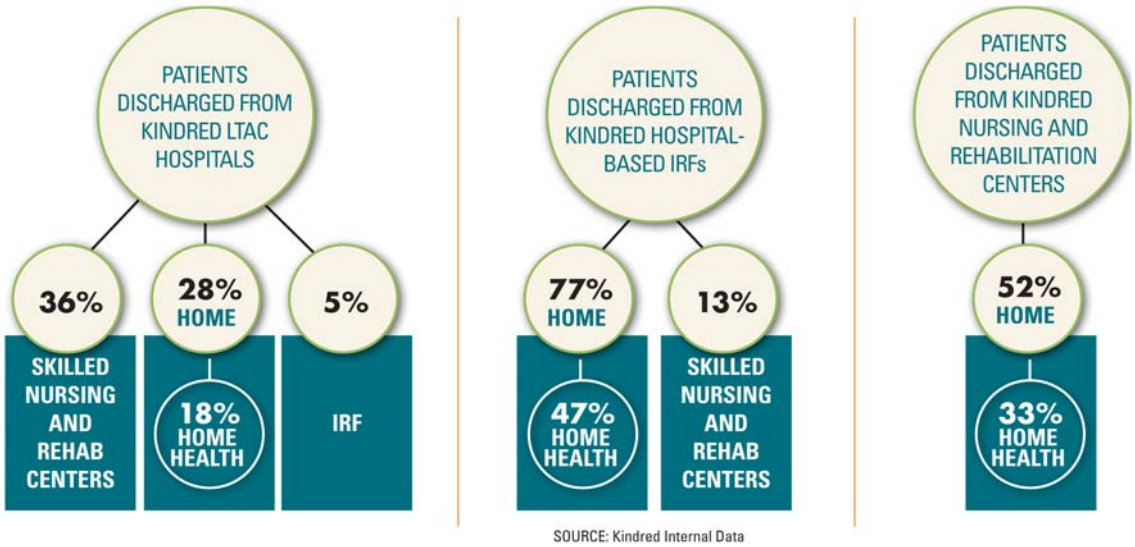
But I would be remiss in not pointing out that achieving even modest levels of interoperability is technically very difficult and expensive. And while a growing number of hospitals and physician practices are investing in electronic health records because of government financial support, only a tiny portion of the billions of dollars available for health information technology in the Stimulus Package was made available to post-acute providers, so the investment in HIT for the post-acute sector will lag other healthcare sectors, as documented in a recent Health Affairs article. [2]

Clinical Criteria for Post-Acute Levels of Care and Care Management Capabilities

Another key enabler for care integration between acute and post-acute sites of care is clinical criteria for post-acute levels of care and the use of clinical care managers across an episode of care. This is a particularly important strategic initiative for Kindred since, as noted above, patients often need multiple post-acute services to meet their needs and it is vital to coordinate these services to achieve care integration for the patient and cost savings for the system. The following chart shows the number of Kindred patients who are discharged from our own settings to other post-acute settings which demonstrates two key points: The number of patients returning home from all sites of Kindred post-acute care is increasing; and it is important to coordinate care between settings to achieve quality and cost control objectives.

[2] "Electronic Health Records: Hospitals Ineligible For Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records" Health Affairs March 2012 31-3505-513. Larry Wolf, Jennie Harvell and Ashish K. Jha.

Kindred Is Working Towards Determining the Most Appropriate Care Setting For Patients as they Continue Their Care Throughout a Post-Acute Episode



We are piloting several different initiatives across the country aimed at achieving these goals, including: centralized admissions for all Kindred post-acute sites of care to help discharge planners determine the appropriate site of care based on clinical criteria and patient need; clinical programs in Kindred post-acute settings that are tailored to meet the needs of acute hospitals in the market to promote coordinated care; care management strategies that focus not just on appropriate site of care upon hospital discharge but also throughout a patient's entire episode of care, including the post-acute episode; clinical criteria to help determine when patients are ready to transition to another site of care, including home, without increasing the risk of quality problems or re-hospitalization; and direct admissions to post-acute sites of care (including developing urgent care centers) to avoid costly acute hospitalizations.

As noted above, communication between sites of care is key, as is the ability to transmit patient information across an episode of care electronically. But there is no substitute for clinical care managers on the ground to ensure smooth transitions for patients throughout the healthcare system and helping to determine which clinical setting is appropriate based on patient need and when transitions can safely occur. In addition to physician coverage across sites of care, Kindred is also testing models of nurse practitioner and other clinical nurse specialists serving as "care managers" to help manage a clinical episode of care.

We are also testing models of integrated care targeted at getting patients home faster and in a way that prevents re-hospitalizations. In Dayton, Ohio, for example, we are piloting a program where Kindred's home health care managers conduct pre-discharge assessments of patients in Kindred Skilled Nursing and Rehabilitation Centers

to make sure transitions home are smooth. Part of this assessment includes an evaluation of the continued need for physical, speech and occupational therapy at home. Since Kindred's RehabCare therapists provide therapy in both settings, the functional gains achieved at the skilled nursing and rehab setting, which enables the patient to return home, can be continued in a seamless way, both to continue functional improvement as well as reduce the risk of re-hospitalization.

Quality Measures that Transcend Sites of Care

As noted by MedPAC, providers, payers and regulators need quality measures to coordinate care between settings, to achieve quality improvements, and to reduce costs. 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. This lack of common quality measures impedes effective care management across an episode of care.

While policymakers test different ways to produce common quality metrics such as through the recently released CMS study, PostAcute Care Payment Reform Demonstration" ("PAC-PRD"), Kindred has several innovation pilots underway. For example, we are pilot testing use of a "Functional Outcome Measure" (which measures functional improvement produced by a course of rehab) across an entire episode of care, including the acute hospital and post-acute stay. These measures are collected and displayed on an IPAD so that both clinicians and patients can see, in real time, where they are in their recovery cycle. Collecting and using this common measure across both the acute and post-acute episode promotes continuity of care as the treatment protocols used, and the functional gains achieved, can be continued from setting to setting. Again, since Kindred therapists provide care across all settings, this also promotes continuity of care and efficient delivery of services.

Aligned Payment Incentives Between Payers and Providers

All of the key enablers described above that promote care integration will also be needed to support a payment system that is more integrated. As noted, the current fee-for-service payment model contributes to a fragmented delivery system and payment inefficiency. It also discourages aligned incentives between providers and between payers and providers. Today, there are separate payment systems for each post-acute provider and insufficient criteria to guide appropriate patient placement. Today, payment systems do not encourage post-acute providers to reduce lengths of stay. In fact, providers who reduce lengths of stay are penalized because patient care costs are front-loaded and payment systems do not recognize this fact and can produce payments below costs for very short lengths of stay. Today, post-acute providers are not rewarded or penalized for re-hospitalization rates. And today, post-acute providers are not paid based on the quality outcomes achieved.

The Committee should recognize that it will take time to transform our current payment system into one that pays for value, rather than volume. In the meantime, I wanted to share a few Kindred pilots with managed care payers that can help shed light on how the payment system might be designed for the future. For example, Kindred has developed with one physician-led managed care organization a pricing model that reflects different levels of care based on patient characteristics for multiple post-acute services. The levels of care are determined both by patient characteristics and the services needed in each post-acute setting. The pricing agreement is supported by a centralized admission infrastructure as well as physician-led care management used to assess level of care, appropriate length of stay, and movement between sites of care.

We are also in the process of developing "pay for performance" payment adjustments to this and other contracts with managed care organizations to promote alignment of interests between payer and post-acute provider. These payment adjustments include, among others, shared risk and gain around: 1) reductions in lengths of stay; 2) reduced re-hospitalizations; 3) quality improvements, including patient experience measures; and 4) discharge rates home. As discussed below, we view "pay for performance" payment adjustments as a critical bridge to a fully integrated payment system, including the concept of payment of a fixed cost for a full episode of care.

Towards Delivery System Reform and Integrated Care: Barriers and Opportunities

In some ways Kindred is uniquely situated to support delivery system reform through integrated care because of the diversity of our post-acute service lines and our national scope which has provided us an opportunity to work together with our partners in the field to test new models of integrated care that are tailored to the needs of local communities. But we are by no means unique. Many post-acute providers—LTACs, IRFs, SNFs, Home Health, Hospice providers--are likewise expanding their capacity to meet the diverse needs of patients, establishing closer linkages with hospitals, health systems, ACOs and managed care payers, making investments in health information technology and developing care management capabilities to prepare for a more integrated system.

And all providers face the same challenges in making progress towards these shared goals, some of which I would like to highlight for the Committee. I would also like to share a few ideas for incremental progress as we work together towards comprehensive reform.

Payment Instability under the Current System

Kindred recognizes our shared obligation to reduce costs and have supported efforts to stem the rise in healthcare expenditures as part of our nation's debt reduction imperative. Over the last several years, all healthcare providers have been subject to tremendous reimbursement pressures as Congress, CMS and private payers have been forced to reduce provider payments to address this national crisis. At the same time, I urge the Committee to consider the impact of additional payment cuts—including the

impending 2% sequestration cut to Medicare payments beginning in January 2013 and continuing for 10 years—on our ability to continue the kinds of innovation pilots I have described today. Innovation requires stability, and more payment cuts will cause a level of instability that I fear will prevent the kind of innovation needed to transform our healthcare system.

We can reduce costs and overall spending by reforming our delivery and payment system – through reduced lengths of stay, reduced hospitalizations, investments in electronic health records, investing in care management, and improvements in quality. But achieving these long term goals will required investments in the short-term, and making these investments requires a measure of stability and confidence in the current payment systems. As noted by a prominent policy expert: "Before provider payments are reduced, our payment system must be reformed to encourage the more efficient delivery of care…so that new delivery models can gain traction." [3]

Address FFS Payment Rules that are Inconsistent with Integrated Care

As we work together towards a more integrated delivery and payment system, I urge the Committee to consider incremental reforms to the current fee-for-service payment systems that inhibit innovation and progress towards a more rational system in the future. There are many examples that I would be happy to discuss with the Committee, but I would like to mention two specific ideas in the time that I have.

First, as I have mentioned, it is important that acute and post-acute providers and payers have aligned incentives to achieve the shared goals of improved care and lower costs. An immediate focus on reducing re-hospitalizations is an area where providers and payers can be aligned. I urge the Committee to consider ideas from post-acute providers and others about ways that the payment system can encourage reduced hospitalizations on the one hand, and discourage high rates of re-hospitalizations on the other. Acute hospitals are already incentivized by the payment system to address this important issue. I see no reason why post-acute providers should not also have "skin in the game" so that interests are aligned.

Second, there are changes to the current fee-for-service payment system that can encourage appropriate patient placement into post-acute settings based on patient needs and align Medicare payments more closely with patient characteristics and care needs. For example, the so-called "IRF 60%" rule, which defines appropriate patient criteria for admission to an IRF, has had the effect of stemming growth in overall IRF spending and encouraging appropriate use of this post-acute setting. Likewise, I commend Senators Roberts and Nelson, both members of this Committee as well as several Committee co-sponsors, for introducing last session S. 1486, The Long Term Care Hospital Improvement Act. This legislation, like the "IRF 60% Rule," would more clearly define the role of LTACs in the healthcare continuum as treating the nation's most medically complex patients. It would also reduce Medicare spending by ensuring only patients who

[3] Mechanic, Robert E.; Altman, Stuart H. "Payment Reform Options: Episode Payment is a Good Place to Start." Health Affairs – Web Exclusive (2009): 262.271.

require the intensive services provided by LTACs are admitted and treated in that post-acute setting. These types of incremental reforms to current fee-for-service payment systems are a helpful and necessary bridge to a fully integrated delivery and payment system.

On behalf of Kindred, I would like to thank the Chairman and the Ranking Member again for the opportunity to share our perspective on delivery system reform and some of the innovative projects we are pursuing with our partners in the field. I started my comments by emphasizing the need for collaboration, trust and teamwork between providers, payers, and policymakers to achieve delivery system reform. I would like to close my comments by re-emphasizing this point and committing to the Chairman, the ranking Member and the entire Committee that providers stand ready to work with you and others in the healthcare community to transform our healthcare system, beginning with incremental reforms that can produce immediate results. Our ability to do so will depend critically on some measure of payment stability and confidence in the short-term and incremental reform of our current payment system to enable and promote the type of innovation that needs to occur to transform our system in the long term.