Congress of the United States
Washington, DC 20515

June 19, 2013

Dear Stakeholders:

Medicare post-acute care (PAC) providers play an important role in the continuum of care for Medicare beneficiaries, providing important services to those beneficiaries recovering from an acute hospital stay. Medicare spending on PAC, which includes services provided by long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled-nursing facilities (SNF) and home health agencies (HHA) was $62 billion in 2011.

The Medicare PAC payment systems face a number of policy challenges. Medicare's rules do not clearly delineate the types of patients who are appropriate for each setting. This lack of placement guidelines, combined with the fact that PAC providers are not required to admit all beneficiaries, nor are they all capable of meeting all care needs, results in varying mixes of patients across facilities. The quality of care and patient outcomes often cannot be compared across settings, making it impossible to evaluate the comparative efficacy of services provided in different settings.

Furthermore, PAC providers may be paid very different rates to treat beneficiaries with similar medical conditions and health status. The uneven availability of PAC providers across markets and multiple payment systems, combined with the lack of placement guidelines mentioned above, results in a wide variation in the use and cost of post-hospitalization care for Medicare beneficiaries.

Recent analyses have spotlighted the wide variation in utilization by Medicare patients in all sectors of PAC, as well as vast differences in Medicare margins among providers. Table 1 below shows this variation.

Table 1 – PAC Medicare Data (2011)

PAC Setting	Annual Medicare Expenditures	Annual Medicare Beneficiaries	Average Medicare Margin
Home Health	$18.4 billion	3.4 million	14.8%
SNF	$31.3 billion	1.7 million	22-24%
IRF	$6.5 billion	371,000	9.6%
LTCH	$5.4 billion	123,000	6.9%
TOTAL	$61.6 billion	5.6 million	

SOURCE – Medicare Payment Advisory Commission March 2013 Report to Congress

The deficit reduction, budget, and delivery system reform proposals put forth by the Medicare Payment Advisory Commission (MedPAC), the Obama Administration, the Bipartisan Policy Center (BPC) and Simpson-Bowles, have all included variations on PAC reforms. Table 2 below shows these reform ideas. These reforms may require interim steps, such as further development of quality measures and refinement of assessment tools.

Table 2 – Comparison of PAC Reform Ideas

PAC Ideas	MedPAC	BPC	Simpson-Bowles	FY14 President's Budget
PAC Market Basket Cuts	X		X	X
Site Neutral Payment	X		X	X
IRF "75% Rule"	X		X	X
SNF Readmission Penalty	X			X
Bundled Payment	X	X		X

We find the substantial variation in Medicare spending, utilization, quality, and Medicare profit margins within the post-acute sector troubling. Our goal should be to ensure that Medicare beneficiaries receive the right PAC, in the right setting at the right time with the highest level of quality and that taxpayers and beneficiaries are paying the right amount for the care that is delivered. To aid us in PAC reform policy development, we are requesting the following:

1. Feedback on the proposals included in Table #2and other deficit reduction proposals, including submission of additional ideas that will improve PAC payment accuracy, combat fraud, and address variation in utilization.
2. Feedback on the proposals and related questions pertaining to options for reforming PAC listed below.

Please respond within 60 calendar days (August 19).

Please submit all written comments to the House PAC mailbox at postacutecarereform@mail.house.gov—AND—the Senate PAC mailbox at postacutecarereform@finance.senate.gov. **Note: all submitted comments shall be considered part of the public record.**

Options for Reforming PAC

Please provide information and ideas on the types of long-term PAC reforms that will help advance the goal of improving patient quality of care and improving care transitions, while rationalizing payment systems and improving program efficiency. Please provide specific responses to the following questions, which cover a number of policies under consideration by the Senate Finance and House Ways and Means Committees. In addition, please feel free to offer additional proposals that respond to the goals outlined above.

Quality

- How can payment reforms be structured to incentivize improvement in quality of care, including improvement in care transitions?
- What quality measures already exist or are already under development that can be used to advance PAC payment reforms?
- What gaps in PAC quality measures exist? What steps can be taken to accelerate development of measures to advance various PAC payment reforms and ensure continued improvement or evolution of measures in the future?
- Are there current quality measures that can be applied across multiple PAC settings (i.e., functional status, mobility improvement, etc.)?

Assessment Tools

- To what extent can existing patient assessment instruments, including the Outcome and Assessment Information Set (OASIS), Minimum Data Set (MDS), or IRF Patient Assessment Instrument (IRF-PAI), be used or modified to help form the foundation for broader payment reform, like bundling and site neutral payments?
- To what extent is the CARE assessment tool useful in helping determine appropriate care settings for patients?
- What aspects of the CARE tool need to be improved to ensure accuracy in reporting to CMS, public reporting, or for use in payments? The Center for Medicare and Medicaid Innovation (CMMI) has proposed using a modified version of the CARE tool as part of the Bundled Payments for Care Improvement (BPCI) Initiative. Is the B-CARE tool (modified CARE tool), currently proposed for use by the BPCI program, a more appropriate measure?
- What other tools can be used to enhance a referring provider's ability to ensure beneficiaries receive care in the right setting?
- What is preferable: (1) adding new questions to existing assessment tools (OASIS, MDS or IRF-PAI); or, (2) capturing data elements in a new assessment tool?

Value Based Purchasing

- Should the existing PAC systems be transitioned to Value-Based Purchasing (VBP) and if so, what further steps are needed in order to make that transition? Should Congress consider a broader VBP program for all PAC settings, or pick specific settings? How soon should PAC VBP program(s) begin?
- What performance measures should be used to assess PAC performance improvement?
- What payment model should Congress consider for implementing a program and why? Should the system rely on penalties, rewards, a combination thereof or something else? Should PAC VBP programs address both improvement and attainment on quality measures?

Reducing Hospital Readmissions

- Should Congress consider a broader readmissions reduction program for all PAC settings, or pick specific settings?
- What payment model (penalty, shared savings, etc.) should Congress consider for implementing a readmissions reduction program?
    - Can the SNF VBP demonstration or the hospital readmissions program be used as a model for PAC readmission program(s)?
- Readmission reduction efforts can use measures of all-cause readmissions (as is currently the case with the existing inpatient hospital readmissions program) or all-cause measures that may be modified for exceptions such as non-preventable admissions (e.g., accidents). How well developed are those measures? Which type of measure is preferable and why?
- Readmission reduction efforts can also use condition specific measures or all-condition measures. How well developed are those measures? Which type of measures, condition-specific or all-condition, are preferable and why?
- Readmissions programs may need to rely on measures that are available and evolve to other measures that may be preferable for policy purposes; how can we assist in this evolution of measures?
- How soon should readmissions reduction program(s) begin?
- What other payment reforms can be made to incentivize post-acute providers to work with other care settings to lower the rate of readmissions?
- The FY14 President's budget and MedPAC have both articulated a SNF readmissions program. What are the pros and cons of these approaches?

Bundled Payments

- There are various ways to structure PAC bundled payments (e.g., PAC only; PAC and inpatient; PAC, inpatient, and physician). What are the pros and cons of each model? Is there an optimal model or are certain models better for different circumstances? Who should manage these payments?
- What are the advantages and disadvantages of the BPCI models as currently proposed by the CMMI?
- What additional types of bundled payments should be considered?
- What steps need to be taken to protect against stinting or other unintended consequences in a bundled payment initiative?
- Other than BPCI, how can bundled payments be advanced and tested?
- Should Congress and/or CMS develop additional bundled payment initiatives prior to implementation and findings from BPCI? If so, how can they be accomplished?
- How can third-party conveners or managers help manage bundled payments?
- Should Congress consider establishing virtual bundles that rely upon existing Medicare PAC fee-for-service payments?
- What factors should Congress consider when directing the Secretary to establish reimbursement for bundled payments?

- How should Congress build-in protections to ensure providers do not induce demand simply because of a bundle's construct (for example, how can Congress ensure that providers are not ordering an inpatient admission just to receive a bundle because an inpatient-PAC bundle may be the highest reimbursed option for a particular condition)?

Site Neutral Payments

- Are some PAC payment settings and/or conditions more ready for site neutral payment than others?
- MedPAC recently articulated a site neutral payment approach between LTCH and Inpatient Prospective Payment System rates. What are the pros and cons to this approach?
- The FY14 President's budget articulated a site neutral payment approach for selected conditions between IRF and SNF payments. What are the pros and cons to this approach?
- MedPAC and the President have articulated near-term policies that move toward site-neutral payment. Are there other near-term site neutral policies that are close to ready for implementation?
- What criteria should be used to determine if a site-neutral payment is appropriate for a particular *condition* and for a particular *setting*?
- There are two potential ways to approach a site neutral payment: (1) equalizing—or (2) narrowing the reimbursement paid for services in two different settings. What are the pros/cons to using these approaches when establishing site neutral payments among PAC settings?
- What existing policies are appropriate to consider when determining whether there should be a difference in reimbursement among PAC settings?

Other Questions Raised by Alternatives to Fee-for-Service (FFS) Payment

- What, if any, is the ongoing role for FFS as we move to PAC reform? What percentage of reimbursement needs to be put at risk within the various types of reforms outlined in your comments to incentivize participation in alternatives to FFS? Who should manage these payments?
- What patient and facility level data may be needed to design any of the systems discussed above?
- What types of transitions may be needed in moving to any of the systems discussed above?
- These new payment systems may pose questions for existing policies (PAC transfer policy, 3-day hospital stay, etc.) and program integrity measures (anti-kickback, anti-trust, etc.) that were developed in a FFS context. Do these existing policies and program integrity measures need to be modified to operate in PAC reform world? If so, how?
    - To what extent are providers willing to take more financial risk if more of these policies can be altered?
- Are there existing policies that must remain in place when FFS payment still exists?

Budgetary Implications

- How will payment reforms lower federal spending, and to what extent? What types of efficiencies can be expected?

Beneficiary Protections and Issues

- If Congress alters incentives, what steps are needed to ensure that beneficiaries are protected and receive care in the appropriate setting?
- How should issues of beneficiary preference be accommodated (e.g., preference for a provider closer to home/family)?
- What steps need to be taken so that payment reform does not create incentives to avoid certain patients or inappropriately reduce care?
- How should beneficiary cost-sharing be addressed in any new PAC payment system, including site neutral, bundling, and others addressed in this letter?
- Are there mechanisms other than cost-sharing to encourage Medicare beneficiaries to more appropriately select PAC services?

Thank you for taking the time to provide feedback on these important ideas for PAC reform. We look forward to reviewing your submissions.

Sincerely,

Max Baucus
Chairman
Senate Finance Committee

Dave Camp
Chairman
House Ways and Means Committee

Orrin G. Hatch
Ranking Member
Senate Finance Committee

Sander M. Levin
Ranking Member
House Ways and Means Committee