COMMITTEE ON
WAYS AND MEANS
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The President’s and Other Bipartisan Proposals to Reform Medicare: Post-Acute Care (PAC) Reform

Summary

Current Law

Home Health Agencies
Under current law, beneficiaries who are generally restricted to their homes and need skilled care (from a nurse or physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency (HHA) personnel can provide skilled nursing care; physical, occupational, and speech therapy; medical social work; and home health aide services.

Home health agencies are paid a pre-determined daily rate for each 60-day episode of care, based on patients’ conditions and service use, and then adjusted to reflect the level of market input prices in the geographical area where services are delivered. Medicare made home health payments totaling nearly $18.4 billion in 2011.

Beneficiaries are not required to make any copayments for home health services.

Skilled Nursing Facilities
Under current law, beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). SNFs are the most commonly used post-acute care setting. Medicare pays SNFs a predetermined daily rate that is expected to cover operating and capital costs. In 2011, Medicare paid $31 billion for SNF stays.

Beneficiaries have no cost-sharing for the first 20 days of skilled nursing care in each benefit period. However, they must pay $144.50 per day for days 21–100 and all costs for each day after day 100 for a spell of illness.

Inpatient Rehabilitation Facilities
Under current law, beneficiaries who need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy are eligible for services in inpatient rehabilitation facilities (IRFs). In order to receive IRF services, beneficiaries generally must be able to tolerate and benefit from 3 hours of therapy per day. IRFs are paid predetermined per-discharge rates based primarily on the patient’s condition (diagnoses,

functional and cognitive statuses, and age) and market area wages. Medicare payments to IRFs were an estimated $6.5 billion in 2011.

Long-term Care Hospitals (LTCHs)
Under current law, beneficiaries who with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care hospitals (LTCHs), which must have an average Medicare length of stay greater than 25 days. LTCHs are paid predetermined per-discharge rates based primarily on the patient's diagnoses and market area wages. Payments to LTCHs were an estimated $5.4 billion in 2011.

Fiscal Year 2014 (FY14) President's Budget Provisions
To address concerns with the sustainability of the Medicare Hospital Insurance trust fund, the Obama Administration has identified several key policies to reform PAC within the Medicare program. In the President's FY14 budget, the Administration focused on five key PAC reform policies: 1) reducing market basket updates for home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs); 2) creating site neutral payments between IRFs and SNFs for certain procedures; 3) modifying the criteria required for IRF status (the so-called "75 percent rule"); 4) establishing a SNF readmissions program; and 5) creating PAC bundled payments.

Reducing Market Basket Updates for HHAs, SNFs, IRFs and LTCHs
Every year the Secretary of the Health and Human Services (HHS) is required, by statute, to update the "market basket" in each Medicare fee-for-service (FFS) payment system. CMS determines an annual index for each market basket. The index estimates how much more or less it costs a health care provider to purchase the same mix of goods and services. The Office of the Actuary (OACT) within CMS is responsible for producing the CMS market baskets for each payment system.

In his FY14 budget, President Obama proposed to realign costs by reducing the market basket updates annually for HHAs, SNFs, IRFs and LTCHs by 1.1 percent beginning in 2014 through 2023. President Obama based this proposal on recommendations from the Medicare Payment Advisory Commission (MedPAC).

The FY14 President's budget estimated that this policy would save $79 billion over 10 years. The Congressional Budget Office (CBO) estimated that this policy would save $43.6 billion over 10 years. The majority of the difference between these two estimates comes from CBO's assumption that Congress will not act early enough to realize FY14 savings.

Creating Site Neutral Payments Between IRFs and SNFs for Certain Procedures
Unlike Medicare Advantage, there is generally much less coordination of care for beneficiaries in FFS Medicare. As a result, beneficiaries often do not receive post-hospital care in the right setting, at the right time. Policy experts have argued that much

of the care beneficiaries receive in IRFs could also be provided in SNFs with the same level of quality, at a lower level of cost.

In his FY14 budget, President Obama proposed to adjust payments for three conditions involving hips, knees and pulmonary conditions, as well as other conditions selected by the Secretary. The President notes that although these conditions are commonly treated by both IRFs and SNFs, Medicare payments are significantly higher when services are provided in an IRF. The proposal further suggests that "IRFs provide intensive inpatient rehabilitation that may not be appropriate for patients with relatively uncomplicated conditions that could be treated in a SNF."

The FY14 President's budget estimated that this policy would save $2 billion over 10 years. CBO estimated that this policy would save $1.3 billion over 10 years.

Modifying Criteria Required for IRF Status (the so-called "75 percent rule")
In 1983, Congress changed reimbursement for general acute hospitals from cost-based reimbursement to a prospective payment system (PPS), which pre-determines a rate for a bundle of care. This fundamental change in reimbursement did not apply to IRFs. Instead, IRFs were allowed to continue to receive cost-based reimbursement as long as they complied with a "75 percent rule."

The 75 percent rule required IRFs to ensure that a minimum of 75 percent of its patients have a qualifying condition. In 2000, legislation transitioned IRF reimbursement from cost-based reimbursement to a PPS. During this transition, CMS suspended the 75 percent rule. In 2004, CMS reinstituted the 75 percent rule with a "revised" list of qualifying conditions (expanding the number of conditions from 10 to 13, and eliminating simple knee and hip replacement treatments). The 75 percent rule was to be phased in over a 4-year period. In 2007, with the 75 percent compliance threshold set at 65 percent (due to the phase-in), Congress overrode the 65 percent threshold and locked the threshold in permanently at 60 percent.

In his FY14 budget, President Obama proposed to increase the 60 percent threshold to 75 percent. The FY14 President's budget estimated that this policy would save $2.5 billion over 10 years. CBO estimated that this policy would save $1 billion over 10 years.

Establishing a SNF Readmissions Program
ObamaCare established the first readmission penalty program for Medicare providers in the acute care hospital setting. The hospital readmissions program is currently focused around three conditions: (1) heart failure; (2) heart attack; and (3) pneumonia. The maximum penalty for a hospital in FY13 is one percent of the market basket. For FY15, CMS has intends to add two additional conditions: (a) chronic obstructive pulmonary disorder; and (b) hip and knee replacement, with maximum penalty of 3 percent of the market basket.

In his FY14 budget, President Obama proposed a similar penalty program for SNF readmissions. The President cited a MedPAC analysis that "nearly 14 percent of

Medicare patients are readmitted to the hospital for conditions that could potentially have been avoided," as the reason for the proposal. The SNF readmissions penalty would reduce the market basket up to 3 percent for SNFs with high rates of readmissions, beginning in 2017.

The FY14 President's budget estimated that this policy would save $2.2 billion over 10 years. CBO estimated that this policy would save $1.3 billion over 10 years.

Creating PAC Bundled Payments

One of the fundamental flaws of FFS Medicare is that it encourages volume over value. Providers are incentivized to provide more services because they generate more revenue, while the full burden of risk is on the American taxpayer. Bundled payments, and other alternative payment mechanisms, have the potential to remove the volume incentive contained in the FFS Medicare program.

In his FY14 budget, President Obama proposed to bundle PAC services (for HHAs, SNFs, IRFs and LTCHs) for at least half of the total payments for PAC providers. In 2018, rates would be based on patient characteristics and other factors and would be set to yield a permanent, cumulative adjustment of -2.85 percent by 2020. Under the President's proposal, beneficiary co-insurance would equal levels under current law.

The FY14 President's budget estimated that this policy would save $8.2 billion over 10 years. CBO estimated that this policy would save $5.5 billion over 10 years.

Assumptions

With the exception of the PAC bundle proposal, staff did not make any policy assumptions in the interpretation of the FY14 President's budget proposals on modernizing beneficiary cost-sharing. Staff requested specifics from the Administration to enable the drafting of the policies. When possible, staff updated legislative language that was previously drafted by the Administration for purposes of negotiations during Joint Committee in 2011.

PAC Bundle Assumptions

- The FY14 President's budget proposal would establish a transition period prior to a full prospective payment system (PPS), with a partial new PPS beginning no later than 2018
  - Assumes "2018" is FY2018 (October 1, 2017) to begin the proposal
- Legislation text follows the construct, in part, from section 1115A of the *Social Security Act*, the Center for Medicare and Medicaid Innovation
  - Applicable conditions for bundles were suggested by CMS to reflect the conditions currently being considered under the Bundled Payments for Care Improvement Initiative (BPCI)
  - The Secretary is granted broad waiver authority under title XVIII and title XI for implementation of the PAC bundle
- Follows the construct, in part, from section 1886D of the *Social Security Act*

    - Quality measure reporting will be required and performance data will be publicly reported
    - The Secretary shall pursue an evaluation
    - The Secretary shall submit two Reports to Congress
- The first provider of PAC services after a hospitalization is the provider who receives the bundled payment
- The Secretary would establish a PAC bundle market basket, which would be updated annually