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Darrell G. Kirch, M.D.
President and Chief Executive Officer

April 15, 2013

The Honorable Dave Camp
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin Brady
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Joe Pitts
Chairman, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Camp, Upton, Brady, and Pitts:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your continued efforts to reform the Medicare physician payment system. In February 2013, the AAMC submitted comments on the Sustainable Growth Rate (SGR) Repeal and Reform Proposal presented by the House Ways and Means and Energy and Commerce Committees. After receiving and reviewing stakeholder feedback, the Committees have presented a second iteration of the proposal with more detail and specific questions about how to implement successful payment alternatives for physician services. The updated proposal describes three phases: Phase I would repeal the SGR and create stable updates for a period of time; Phase II would place a portion of the physician payment at risk for quality, and; Phase III would incorporate payment based on efficiency as well as quality.

The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. Clinical faculty practices often work closely with their teaching hospital partners in systems to provide coordinated care for complex and vulnerable patients while also performing research and training the next generation of clinicians. As Congress considers alternative payment models, it is essential that any legislation allows for models that measure and reward the quality and efficiency of care at the system level, rather than just measuring care at the individual clinician level. This helps promote care coordination and patient-centered care. The payment also needs to recognize, and not penalize, systems that provide complex services and care for vulnerable patients.

The AAMC believes it is absolutely crucial that Congress reform the SGR formula to ensure access for beneficiaries and stable payments for providers. However, one critical component that often is overlooked in the payment discussion is the need to ensure there are enough physicians to meet the

country's needs, particularly with a growing number of Medicare beneficiaries. The AAMC estimates that by 2020 the United States will face a shortage of more than 91,000 physicians, equally distributed between primary care and subspecialist physicians. These are the doctors that Medicare beneficiaries disproportionately rely upon for health care. Our nation's medical schools and teaching hospitals have increased their capacity to train new doctors; however, the number of federally-supported residency slots has been stagnant since 1997. It is critical that the 113th Congress address the need to increase Medicare support for Graduate Medical Education (GME). I urge you to take this opportunity to address the physician shortage and guarantee provider access to Medicare beneficiaries and all patients by increasing Medicare support for GME.

The AAMC notes that there is no mention of how to pay for the SGR proposal. We remain concerned that Congress will look exclusively to the Medicare program to find the required savings. This approach would have an adverse effect on beneficiaries and on the teaching hospitals and teaching physicians that provide care to them. Using cuts in Medicare support for teaching hospitals' missions to address physician reimbursement inequities is counterproductive and shortsighted, damaging institutions that are critical components of our health care system. **The AAMC cannot support any new payment system that is financed by redirecting funds currently supporting critical health care expenditures, particularly cuts that would disproportionately impact the nation's teaching hospitals and teaching physicians.**

Phase I and Phase II Questions

Positive Update and Variable Rate

Throughout all phases of the new model, Congress needs to ensure a positive update so that physician practices can be solvent during the transition. Access to physician services has to be maintained, especially as more people enter the Medicare program.

The proposal states that in Phase II, physicians will have a base rate and a variable rate. The variable rate, called the Update Incentive Program (UIP), will be contingent on performance related to quality initiatives. However, the proposal does not specify how much of the payment will be at risk. The AAMC suggests that Congress phase in the variable rate over time and limit the maximum variable rate to 2-3 percent, similar to the payment that is at risk in hospital performance programs.

Group Practice Reporting

The AAMC appreciates that the proposal allows providers the option to be measured and benchmarked at the group practice level. We also encourage Congress to include legislative language that requires the Centers for Medicare and Medicaid Services (CMS) to use a flexible definition of "group." CMS currently defines group practices for its quality reporting programs only by tax identification number (TIN), yet TIN is not always the logical definition for a group. For example, some academic centers operate as a single multispecialty practice, yet each department has its own TIN. Similarly, defining groups by TIN does not allow CMS to easily track changes to group practices that result from mergers or dissolutions.

Role of National Quality Forum

Measuring the quality of physician services is challenging due to the variety of physician practices. The AAMC believes that most measures used by clinicians should be endorsed by a consensus-based

organization, such as the National Quality Forum (NQF). We also acknowledge that some subspecialties have valuable measures that have not been NQF endorsed. We support a process that allows these measures to be used, particularly if they fill a needed gap. We want to ensure, however, that these non-endorsed measures are used sparingly and that their use by physicians or physician groups is optional.

Expert Panel Should Include Representatives from Academic Medicine

The proposal calls for an expert panel to advise the Secretary on the establishment and maintenance of the UIP. The AAMC supports the establishment of such an advisory panel and believes the panel must include representatives from large group practices and systems, especially those found at academic centers.

Reward Improvement as Well as Achievement

The Committee is seeking feedback whether or not it is appropriate to reward providers that improve performance in addition to rewarding providers who perform well compared to their peers. The AAMC supports the idea of rewarding performance improvement over time. This format is used in the hospital value-based purchasing program and incents all providers to work towards improving quality.

Determining Peer Benchmarks

We suggest that Congress consider how best to define “peer” for purposes of quality and cost benchmarks. Specialty level comparison may not be accurate due to the wide variation in subspecialty care services that are provided. Often a true peer is better defined by the mix of services a physician (or physician group) provides and the types of patients the physicians sees than by specialty designation. Setting appropriate benchmarks will be important in any reformed payment system.

Phase III Questions

In Phase III, physicians that meet a minimum quality score have the opportunity to earn additional incentives based on efficiency scores. The AAMC understands the importance of measuring efficiency and providing incentives to reduce costs, but Congress must recognize that currently there is little consensus about how to measure efficiency.

Methodology Considerations

Many factors can affect an efficiency score, including the methodology for patient assignment, accuracy of risk adjustment, and selection of the measures used. Since 2008, CMS has been developing quality resource use reports (QRURs) that provide feedback on quality and cost measures. In 2011, the Government Accountability Office released a report detailing the various methodology issues that CMS faced.¹ Following release of that report, CMS has had to revisit most of the methodology assumptions for measuring individual physicians. CMS has also measured cost at the group level. The AAMC has worked with its members to better understand this data, but the current information is presented at an aggregate level with little detail to explain the underlying reasons for the differences.

¹ <http://www.gao.gov/new.items/d11720.pdf>

Inadequate Risk Adjustment

The current Medicare risk score methodology predicts about 11 percent of a patient's costs and does not consider many socio-economic factors and other social determinants that can impact patient health. Teaching physicians and hospitals play a critical role in providing care for Medicare beneficiaries, many of whom are the sickest and most complex of patients. Teaching physicians also provide Medicare beneficiaries with vital primary care and specialized services that may not be available elsewhere in the community. Additionally, academic physicians often serve as resources for other health care providers in communities and across regions, providing consultations and care for Medicare patients who need their specialized expertise. It is crucial that quality measures and risk adjustment methodologies be developed that measure these differences, but do not result in adverse consequences for those physicians who serve these complex populations. We are working with our members to better understand current data and conducting research to determine appropriate modifications to the current risk-adjustment methodologies that would accomplish this goal. Without reliable, sufficient, and fair physician payments from Medicare, beneficiaries' access to many of these services may be jeopardized.

Additional Data is Needed to Reduce Costs

To better manage the cost of patients and to improve care coordination, providers must understand the patterns of care a patient receives. They need to know which patients they are responsible for and what services those patients have used. Currently, providers have limited information about the care received by their patients outside of the system. A payment system that plans to reward on cost and quality data must also commit to timely feedback and supporting data, so that physicians and their partners can rapidly identify and address issues. Ideally this data would be available in real-time, or worst-case, quarterly.

We recommend Congress implement a gradual approach to including resource use in the payment formula. Resource measurement is very important to understand, but given the variety and complexity of methodological issues that are still outstanding, we believe it will be several years before this measurement is accurate enough for payment.

Alternative Payment Models (APM)

Teaching hospitals and their physician faculty have been in the forefront of testing new payment models and health care delivery systems that focus on team-based care. The AAMC is a convener for a group of teaching hospitals participating in the current Centers for Medicare and Medicaid Innovation (CMMI) Bundled Payments for Care Improvements (BPCI) initiative. Our experiences from this initiative inform our comments in this section.

New Payment Models Need Time To Develop

In BPCI, 500 providers were selected from a pool of applicants to test a new payment model. CMMI posted the original request for information (RFI) in August 2011 and the program is scheduled to start July 2013, almost two years after the initial RFI was released. As July 2013 rapidly approaches, CMMI is still working through multiple technical and policy issues and has struggled to provide the participants the necessary (and promised) data needed to calculate the benchmark payment. The BPCI experience suggests that other APMs may require one to two years to setup the infrastructure for the early adopters. Broad implementation of the model to other practices may take several additional years. As Congress sets the timeframe to test new models, it should also consider a backup plan to implement if the new APMs are not functional.

Resources Needed for Alternative Payment Models

As was suggested previously, perhaps the most important resource in any new payment model is having access to timely and reliable data. CMS has a massive infrastructure and struggles to release data. Congress must be prepared to provide the necessary investment for CMS to improve its ability to mine and disseminate data in a timely and reliable fashion.

Practices Should Be Able to Test More than One Payment Option

As new models are being tested, physicians and groups should be able to select to participate in multiple APMs. This may require some rules to ensure that practices are not rewarded (or penalized) twice for patients that appear in multiple models.

Improvements on Current Law

The proposal asked for ways to modify current law and reduce burden to providers of care. The BPCI participants were allowed to submit waivers to help alleviate legal and regulatory barriers to coordinated care. The full list of waivers, and the rationale for requesting the waivers, is provided in Attachment A and provide some guidance to reducing burden. Most waivers focus on ways to redesign care and ensure that it is delivered in the most appropriate setting. For example, one requested waiver is the removal of the 3-day inpatient rule before sending a patient to post-acute setting. Optimal patient-centered care allows for treatment at the best site of care to reduce complications and unintended consequences, and also allows focused resources where they provide the greatest benefit. The clinical improvement could occur at any time and requiring 72 hours in the inpatient setting may in fact result in prolonging care in a setting that is not optimal for the patient. Changes such as the removal of the 3-day stay rule allow providers flexibility to furnish the highest quality and most cost efficient care.

Also of note is that the Federal fraud and abuse laws (civil monetary penalties, anti-kickback, and physician self-referral) were designed to prevent behavior that could occur in a fee for service system. When these laws are imposed on new care models that require team-based care and payment systems that are dependent on meeting quality and efficiency measures, they become a barrier. This barrier was acknowledged when CMS and the Department of Health and Human Services Office of Inspector General (HHS OIG) provided waivers for participants of the Medicare Shared Saving Program. Consideration should be given to extending these types of waivers more broadly, or even to revising the current fraud and abuse laws to better reflect the fraudulent or abusive activity that may occur in these new models of care.

Documentation requirements that are rooted in a fee-for-service system are a major source of burden to physicians who now are moving toward providing care in teams and working towards meeting quality and other metrics. The AAMC believes the complexity surrounding Medicare documentation requirements needs to reflect this change. There always will be a need for documentation as part of quality patient care and to substantiate payment for services. Yet, efforts should be made to change the role of documentation from supporting billing that is based on level of effort (the current evaluation and management system) to supporting the metrics on which payment is based. This, in turn, should lessen the burden on physicians and other providers.

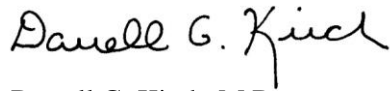
Additionally, Congress has established a myriad of quality reporting and performance programs, including the Physician Quality Reporting System (PQRS), the EHR Incentive Programs, the E-Prescribing Incentive Program, and the Value-based Physician Modifier. Each program has individual

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statutory requirements that make it difficult for the individual provider (or group practice) to know how to meet all the requirements and avoid penalties. While CMS has attempted to align the reporting for these programs, the process remains confusing. Viewing these programs from a single holistic perspective, and aligning the legislative requirements, would minimize the burden for providers.

The AAMC appreciates and supports your efforts to address important issues associated with repealing and reforming the SGR. The Association looks forward to working with you to design and implement a system that preserves care access for Medicare beneficiaries; responsibly slows the Medicare growth rate; and pays physicians and all providers fairly.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive style with a prominent initial "D".

Darrell G. Kirch, M.D.
President and CEO

Appendix A
AAMC BPCI Request for Waivers Application

Medicare Payment Policy (1 of 8): Gainsharing

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application and includes services delivered during the anchor hospital stay and 90 days of post-acute care.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

The specific provisions of the Social Security Act needing waivers are:

*Section 1115A(d)(1) Gainsharing arrangements with providers
Section 1877(a) relating to the Physician Self-Referral Law
Sections 1128A(b)(1) and (2) relating to the Gainsharing CMP
Sections 1128B(b)(1) and (2) of the Act relating to the Federal anti-kickback statute*

Waivers would be limited to arrangements between specific providers with signed agreements and to specific care arrangements for only patients within the designated episode bundles.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

Providers working together and sharing risk and gain with the same goal of comprehensive, coordinated care are the most critical element to improving patterns of care for the beneficiary. Unimpeded referrals, care orders and financial rewards for achieving quality benchmarks are fundamental to success. Currently, providers cannot be financially rewarded by other providers for evidence-based actions that may be in the best interests of the patient. While these rules may prevent nefarious behaviors in uncontrolled, undocumented provider relationships, the BPCI will limit the clinical circumstances, have detailed transparent gainsharing agreements, will document the financial flow of funds and provide an oversight committee to protect against abuse and behavior that would impact the beneficiary. We have provided a detailed description of our Gainsharing model in Section 1 above and need the above mentioned waivers to provide a safe harbor among providers to share those financial responsibilities.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We believe there will be modest cost savings from more uniform evidence-based care protocols and quality driven referrals between providers in the gain-sharing network. Savings will be derived from reducing unnecessary high cost institutional care and less readmissions resulting from improved home health care. More patient centered and coordinated care in the post-acute phase will reduce costs and improve outcomes for the beneficiary. While we have not modeled with specific data, experience shows that overall cost savings could be 5-20%.

Medicare Payment Policy (2 of 8): Three Day Qualifying Stay Rule for SNF Coverage

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application and includes services delivered during the 90 days of post-acute care.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

Medicare Policy requires qualifying hospital stay of 72 hours before transferred for SNF coverage to be available. Summary of rule is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>.

The 3 consecutive calendar day stay requirement can be met by stays totaling 3 consecutive days in one or more hospitals; the day of admission, but not the day of discharge, is counted as a hospital inpatient day. Time spent in Observation status or in the ED prior to (or in lieu of) an inpatient admission to the hospital does not count toward the 3-day qualifying inpatient hospital stay.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

Our hospitals are committed to community based care, wellness, and prevention of readmit risk and we need clinical flexibility in moving patients into the optimal setting based on evidence-based protocols and on care they need, not a mandatory 3 days in an inpatient setting. Most MA patients have waived 3 day rules for this reason. Optimal patient-centered care allows for treatment at the best site of care to reduce complications and unintended consequences as well as allow focused resources where they provide the greatest benefit. SNFs are focused on restorative and supportive care, so once the patient's condition has improved beyond the need for acute interventions, rapid transfer to the SNF, and beginning restorative care will result in better outcomes. The clinical improvement could occur at any time and artificially requiring 72 hours may be requiring an excess of expensive inpatient care. For instance, a patient with a total joint procedure will return to maximal function the faster they are mobilized. Mobilization best occurs in a SNF with intensive physical therapy. Delaying physical therapy due to an artificial 3 day hospital limit can delay safe mobilization. Likewise, a patient who is discharged directly to an outpatient therapy program but has a set-back or needs to return to a safer environment should be able to go to a SNF primarily, as

opposed to being readmitted to an acute hospital. In conclusion, hospitals focus on procedures, acute treatment and post-operative recovery while SNFs focus on rehabilitation to ambulation. Forcing the patient to remain in the hospital for three days can limit their return to full function and increase patient safety risk. Under BPCI, hospitals are financially at risk for all care costs, CMS expenditures are protected and cross-site collaboration is a mandate.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

This policy has the potential to lower the hospital costs (limited by the transfer policy for shorter stays) and reduce readmissions but increase episode costs through greater SNF utilization. By discharging the patient from the hospital earlier when clinically appropriate, there will be less risk of inpatient complications and faster recovery for the patient. However, the goal is not to lower costs within a given provider but rather to lower costs within the entire episode by changing the care settings and providers to produce a faster recovery and improved outcome.

Medicare Payment Policy (3 of 8): Waiver of the “amount, frequency and duration” limit on home health services

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application and includes services delivered during the 90 days of post-acute care.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

Medicare Benefit Policy Manual, Chapter 7 - Home Health Services, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf> states the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

We believe that since our success depends on the aggressive use of Home Healthcare and because the applicant is ultimately responsible for the costs, CMS should waive the “reasonable” limit. The guidance around reasonableness is premised on the traditional fee-for-service model of payment and

the potential abuses of unlimited services. In bundled payment, these limits present barriers to the delivery of high quality cost effective care. The benefits to beneficiaries of this waiver are: patients would benefit from increased flexibility in their care plan, improved quality, improved outcomes, and reduced re-hospitalization. In order to reduce post-acute care costs overall, more aggressive use of home care will be required to support reduced facility utilization and simultaneously reduced readmission rates. Limitations to homecare support could result in patient either unnecessary readmissions or in higher post-acute facility utilization to avert potential readmissions. A case example is a 67 year old man with CHF and diabetes. He has been admitted to acute hospital settings 3 times in the past six months. He is not homebound and still can drive his car despite severe peripheral neuropathy. He has lost 65 lbs in the past six months and has gastroparesis so is not absorbing his food. He has fallen three times at his home due to weakness. He does not want to go to a NH or SNF even though he needs home health services. His needs require flexibility in the amount, frequency and duration of home health visits to check home safety, help monitor and provide nutrition support, set up his multiple medications, insulin monitoring and physical therapy support to gain strength and reduce falls. The current Medicare FFS system actually has far more abuse potential than the BPCI program augmented by this waiver since hospitals are at risk for total service utilization.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We do not estimate any internal cost savings to providers. Total HHA service costs may increase due to this policy waiver but we anticipate the patient will recover with fewer readmissions and a faster timeline and that will save total episode costs and be more patient centered. We do not have specific dollar impacts.

Medicare Payment Policy (4 of 8): Waiver to permit free Pre-Admission Home Evaluation Services

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

OIG Advisory Opinion No. 06-01

<https://oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-01A.pdf> prohibits Home Health Agencies from performing free preoperative home safety assessments for patients scheduled to undergo surgery.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

The current policy results in barriers and complications in arranging post-acute services and can lead to longer inpatient stays and unnecessary post-acute confusion and safety risks for the beneficiary. We request the waiver to permit these assessments only by HHA's participating in the gainsharing network of the bundled payment awardee. It would result in a more informed post-acute care plan for the beneficiary, lessen the likelihood of physical barriers at home causing falls and readmissions and enable a more patient-centered care plan and family member involvement. Pre-assessment and even optimizing function prior to elective procedures, specifically in joint replacement and likely others, has been shown to improve outcomes and final post procedure function. The practice of pre-scheduled admit home assessment is a standard component of our care redesign for surgical episodes at AMCs, and has now been extended to medical episodes as well. The assessment visits can include taping down electrical cords to prevent falls, provide raised toilet seats to prevent hip displacement, assess steps, beneficiary isolation, caregiver support, and household cleanliness. Preventing this in order to maximize patient choice and optimal outcome is not supported by the medical evidence.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We believe this waiver could reduce the inpatient costs by more timely discharges and reduce total episode costs by lesser readmissions and safer post discharge environments for the patients. We do not have specific savings estimates.

Medicare Payment Policy (5 of 8): Waiver of the homebound requirement for home health services

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application and includes services delivered during the 90 days of post-acute care.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

Medicare Benefit Policy Manual 30.1.1, A3-3117.1, HHA-204.1 – Patient Confined to Home Policy can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>. An individual must be confined to home (homebound) in order to qualify for Medicare home health coverage.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

While there are exceptions to the Home Bound requirement if absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment, we believe there are many situations where patients benefit from increased activity outside the home as recovery occurs yet they require certain home health services not available from family members such as medication assistance, therapy, etc. Encouraging patients to assimilate into the community and resume activities should not be counter to providing medical support services. Homebound status creates another artificial barrier to optimal care. For patients who are transferred out of acute care facilities, return to maximal function as soon as possible is the critical, patient centered solution. Home care is the most cost effective post-acute support modality currently available and any limitation on its effective use is problematic. For patients who are able to transition to home but have wound care needs or complex medication regimens requiring support, monitoring, or care but not specifically homebound could actually be harmed by not allowing support at home or by requiring prolonged inpatient care to receive those services. Additionally, given our 90 day episodes, minor exacerbations beyond the acute period may require home care support (medication, reconciliation, parenteral medication administration, etc) despite not being considered homebound.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

HHA service costs may increase due to this policy waiver but we anticipate the patient will recover with fewer breaks in HHA services, fewer readmissions and a faster timeline and that will save total episode costs and be more patient centered. BPCI hospitals will manage total costs and must assure that patients get optimal #/frequency of HHA services in order to manage bundle cost but need this flexibility in who can get HHA services when. Because expenditures for HHA services are part of the risk to the hospital, this policy should have no cost impact to CMS.

Medicare Payment Policy (6 of 8): Waiver of the Part B copay requirement for post-acute services. This is also addressed in the Beneficiary Incentives section because we believe it to be an important incentive for beneficiaries to accept less institutional care in exchange for greater ambulatory and outpatient care.

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

Title 18 Social Security Act, Sec. 1833. [42 U.S.C. 1395l] defines services requiring a 20% coinsurance amount to be paid by the beneficiary and includes most Part B services in our episode bundles.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

If bundled payments result in shorter lengths of stay, less care in SNFs and LTACs and more outpatient care, the patient will be penalized by paying more Part B copays. We are concerned that the disincentive of the higher copays will be a barrier to the patient receiving more post-acute Part B services and negatively affect outcomes.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We do not believe there will be internal cost savings to any provider in the episodes but removing financial barriers to patients receiving appropriate Part B post-acute services will allow services to be rendered that are clinically optimal with no financial barrier and could contribute to an improved outcome. In our proposal, the Part B copay that is not covered by a secondary payer for post-acute services would not be collected from the beneficiary by the OLOL wholly-owned post-acute providers. CMS would continue to coordinate with the secondary payer and remit any remaining copay amount to the Part B provider after claim is settled with secondary insurer.

Medicare Payment Policy (7 of 8): "Three Hour Rule"

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

The three hour rule is a guideline that states that IRF patients must generally require three hours of therapy for five days per week, unless the patient is unable to tolerate that level of therapy. Chapter One, Section 110.4.3. Currently, any patient in a post-acute care setting that isn't able to tolerate 3 hours of therapy must be transferred to a sub-acute care facility.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

Currently, any patient in a post-acute care setting that isn't able to tolerate 3 hours of therapy must be transferred to an acute care facility. This leads to the high rate of readmits from SNFs (>21%). The goal is to return the patient to their home in an efficient, quality-oriented manner while reducing re-hospitalizations; again patients have periods of recovery and periods of stability and should not be punished for failure to consistently meet 3 hour therapy demands.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We do not believe there will be internal cost savings to any provider in the episodes but removing financial barriers to patients receiving medically appropriate and safe services in the least cost intensive environment will improve overall quality and lower total episode costs.

Medicare Payment Policy (8 of 8): Waiver of limits on Beneficiary Inducements

1. Specify the BPCI Model for which you are responding and that you believe may involve this Medicare payment policy.

BPCI Model 2

2. For the BPCI Model that you identify in question 1, specify the clinical condition(s) and the planned service(s) that you believe may be affected by this Medicare payment policy.

This payment policy applies to all conditions (episodes) in our application.

3. Describe the Medicare payment policy, including, if possible, a citation or reference to the statute, regulation, or other source of the policy.

There are beneficiary inducement limits under civil monetary penalty provisions section 1128A(a)(5) of the Social Security Act (the "Act"), or under the exclusion authority at section 1128(b)(7) of the Act, or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute. Providers are generally prohibited from financially (monetary or in-kind) assisting patients with a value greater than \$10 per incident or \$50 per year. We would seek a general OIG waiver of these rules for providers and beneficiaries in the BPCI.

4. For the BPCI Model that you identify in question 1, describe specifically how a waiver of the Medicare payment policy would be integral to the care redesign that you plan. Explain why such a waiver would lead to the program success of the applicant with regard to the BPCI Model.

In some clinical conditions, non-medical cost barriers can delay or impede care and new technology not covered by Medicare would result in better outcomes and perhaps lower overall episode costs. Removing financial barriers to patients receiving medically appropriate and safe services in the least cost intensive environment will improve overall quality and lower total episode costs. There are a

number of specific services such as transportation assistance between facilities, home monitoring devices, therapeutic drug regimens for non-compliant patients and care coordination tablets/devices that exceed that value but would support better care coordination and improved outcomes. In order to limit abuse or “over-inducement”, each hospital awardee would place a dollar limit on the value of the services they will permit for any one inducement and the total of all inducements will not exceed \$300 per episode per beneficiary.

5. For the BPCI Model that you identify in question 1, explain whether you believe a waiver of the Medicare payment policy may result in internal cost savings to any of the partners involved in the planned care redesign. Provide an estimate of the internal cost savings expected, if any.

We do not believe there will be internal cost savings to any one provider and in fact in this case, providers would be incurring added costs in order to lower future utilization and costs.