

BACPAC Draft Questions and Clarification:

PPS vs. New DRG System

1. Will the PPS system still be in place for markets that do not contain a PAC Coordinator?

No. All areas of the country will be sufficiently covered with a PAC coordinator but in the unlikely event that there is not, the same policy as Medicare Advantage will apply.

2. Will the PPS system still exist for markets with only one Coordinator for providers that do not participate within the Coordinator's network?

As currently drafted, no. If during the course of consideration of this and other PAC models, such policy is considered essential it will be incorporated into the model.

3. Will this bill propose a change to reimbursement between the PPS setting and the Critical Access setting for post-acute care? For instance, a PPS hospital is paid on the DRG IP, and APC (or other method) for outpatient, whereas a CAH is @ reasonable cost for both settings. Will CAHs be subject to the CRG methodology outlined in the bill?

CAHs are not part of this post acute care reform proposal and therefore their reimbursement will remain the same. Long term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies will be the key four settings that will be part of the new PAC model.

Providers

1. SNFs are not specifically listed as a PAC Service, are they under the umbrella of Extended Care Services?

This has been modified within the legislation.

2. Request to exclude outpatient physical therapy services from the PAC bundle:

- Page 4, Line 12 - Strike "outpatient physical therapy services"
- Page 4, Line 19 - Add "(v) outpatient physical therapy services."

This also has been modified within the legislation.

Coordinator Issues

1. If a patient opts for a PAC entity, would he/she be waiving his/her right to choose the PAC provider of his/her choice for a 90 day period, or could they opt out at any time?

Patient choice is preserved within the PAC reform model. First, the patient retains their primary physician and works with that physician throughout the 90 day period. Secondly, the patient

chooses the PAC coordinator that they will receive their care. And finally, they will still have a choice of providers from the network established within that PAC coordinators group.

2. What standards and processes would be used to determine “network adequacy” determinations, including the “sufficient number” and “range of healthcare professionals and providers” willing to provide PAC services? This is an important issue, because we see a potential corollary to it in the Medicare Advantage markets for “rehabilitation” benefits. In many instances, “rehabilitation” is interpreted as meaning nursing home/SNF, and rehabilitation hospital services are not covered or are otherwise not utilized, notwithstanding that patients receiving SNF services may in fact have medical/clinical/rehabilitative care needs that should be addressed in an IRF setting/level of care. We would suggest that the language be tightened and clarified in a fashion that will require the PAC coordinator to offer all levels of PAC services if such services are already available in a given market, or if they become available.

The legislation eliminates barriers to access to the various PAC providers, and thereby, allows greater flexibility between the patient’s physician and coordinator to get the patient to the most optimal setting for care. The PAC coordinator’s focus is to provide the most appropriate and best quality of care to the patient to avoid the rehospitalization, and therefore the coordinator has an incentive to drive the most optimal results.

3. There is a need for a bit more specificity around the definition of a “medical director.” At a minimum, we would suggest that a medical director of a PAC entity should be a physician or doctor of medicine with a demonstrated record of practice in an environment pertaining to post-acute care and/or post-acute care placement of patients. Such a physician/doctor would likely have (indeed, probably should have) experience with either rehabilitation/therapy (which covers a component of IRF, SNF, and Home Health services); or the care of ICU or ventilator patients (which covers a component of LTACH and SNF services).

This is helpful and will be considered with our next modifications to the legislation.

4. How will the bundled payment be handled? Will the coordinator receive the payment up front? If so would the coordinator pay the provider claims?

Yes. Initially, all claims will be paid at a level not less than FFS rates. Subsequently, payment will be at rates negotiated between the providers and the coordinator(s) in whose network the providers are participating.

CARE Tool

1. BACPAC places particularly heavy reliance on the CARE instrument, including for PAC placement purposes. The CARE instrument’s efficacy for PAC placement has not yet been demonstrated; many questions remain unanswered as to whether the CARE instrument can be adopted, including whether it should be (several of our hospitals participated in the CARE instrument demonstration). In short, PAC placement decisions should not be based exclusively upon results produced by any patient assessment instrument (CARE or otherwise), though that’s not to say that CARE or other such instruments are unimportant or should not be pursued. Rather, results produced by such instruments should be utilized by doctors, physicians, and other medical

practitioners to help inform their medical judgment and opinion as to what any particular patient's post-acute care needs are and where those needs can be most appropriately and optimally met.

Absolutely. The CARE tool is currently being revised by CMS and recent research has indicated that a shorter CARE tool may be helpful in providing insight as to the most optimal setting for the patient but it is also important to note that the patient's physician and the coordinator will work with the patient to determine the most optimal setting for the patient's care.

Medicare Parts

1. In the initial statement of the bill, it reads "...under parts A & B of Medicare, and for other purposes." Can you define or expand on "for other purposes"?

This language is usual and customary language to ensure that the legislation flows.