American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

August 19, 2013

The Honorable Max Baucus
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Dave Camp
Chairman
United States House of Representatives
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
United States House of Representatives
Committee on Ways and Means
1106 Longworth House Office Building
Washington, DC 20510

Dear Chairman Baucus, Ranking Member Hatch, Chairman Camp and Ranking Member Levin:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide input on ways to improve post-acute care for Medicare beneficiaries. In general, post-acute care services support patients who require ongoing medical management, therapeutic, rehabilitative or skilled nursing care following treatment in a general acute care hospital. These services are vital to a patient's efforts to recover from major health episodes, manage chronic disease and pursue independent, healthy living. The AHA membership includes all of the post-acute settings: home health agencies (HHA), skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH).

The AHA supports efforts to bring meaningful reforms to the post-acute care field that ensure patients' continued access to medically necessary services. Unfortunately, many of the proposals highlighted in the president's fiscal year (FY) 2014 budget proposal, as well as other proposals by the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare & Medicaid Services (CMS), include arbitrary cuts that would threaten patients' access to these services. The AHA is particularly concerned with efforts to establish inpatient prospective payment system (PPS)-LTCH PPS site-neutral payment and IRF-SNF site-neutral payment. The AHA does not agree with the structure of these proposals, and instead supports alternative quality and payment reform proposals discussed in this letter and related attachments.

The AHA believes that rigorous, publicly transparent quality measurement is integral to improving post-acute care. A mix of public quality reporting and pay-for-performance can align the health care delivery system—including post-acute care providers—toward continuous quality improvement, and reward providers that improve. However, any measures adopted for public reporting and pay-for-performance programs must align with national quality improvement priorities and generate accurate data for the care setting being evaluated. Quality reporting and payment programs should use measures endorsed by the National Quality Forum and reviewed by the Measure Applications Partnership to ensure they credibly assess performance and address the highest priority issues. We further urge that pay-for-performance programs, including those intended to reduce readmissions, use incentive structures that both challenge providers to improve and reward them for making progress.

The AHA also believes that the CMS bundling demonstration and shared savings program mandated by the *Patient Protection and Affordable Care Act* are important opportunities to acquire a great deal of information on the clinical, operational and financial considerations of episode payment for hospital, post-acute and other services. Therefore, we support opportunities for post-acute care providers to learn from innovators in the bundled payment and shared savings programs on an ongoing basis, rather than waiting for the completion of these efforts. Furthermore, barriers to clinical integration must be decreased and steps to discourage bundlers from stinting on medically necessary care must be implemented.

In addition, the AHA has long supported legislative efforts to raise minimum standards for LTCH admissions through the establishment of patient criteria. This legislative effort is an important step toward delivery system reform since it distinguishes a unique LTCH role in communities that are reshaping their local delivery system.

Please find attached our detailed comments on these post-acute care reform proposals.

If you have any questions, please feel free to contact Aimee Kuhlman, senior associate director of federal relations, at (202) 626-2291 or akuhlman@aha.org. Thank you again for the opportunity to comment.

Sincerely,

/s/

Rick Pollack

Executive Vice President

ATTACHMENT A

Post-Acute Quality Reporting and Payment: Alignment with National Improvement Priorities is Needed

The American Hospital Association (AHA) believes that rigorous, publicly transparent quality measurement is integral to improving post-acute care. Hospitals and post-acute providers have long supported the need for public reporting of quality measures in order to share important and reliable quality information with the communities we serve, identify opportunities to improve care and track improvements. In fact, the reimbursement of health care providers has been increasingly tied to achieving positive outcomes on quality measures. **We believe that a mix of public quality reporting and pay-for-performance can align the health care delivery system—including post-acute providers—toward continuous quality improvement, and reward providers that improve.**

Unfortunately, federal quality reporting and payment programs have proliferated without strong alignment to national priorities or a fundamental understanding of the most important changes to be made to produce better patient outcomes. As noted in our June 2013 statement to the Senate Finance Committee, the sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance coordination across the care continuum.

As Congress considers expanding quality reporting and payment programs for post-acute providers, we strongly urge it to align those efforts with broader national quality improvement priorities for all health care providers. It should also ensure that measures in the program are endorsed by the National Quality Forum (NQF) to ensure they are sufficiently rigorous to use in accountability programs. The measures also should be reviewed by the Measure Applications Partnership (MAP) before being incorporated into programs to ensure they are aligned with national priorities. Rigorous measures aligned with national quality priorities would ensure focused attention on the most critical areas of improvement and promote an efficient use of limited quality improvement resources. It also would encourage coordination of efforts among all health care providers.

To ensure uniformity of purpose across the health care system, post-acute quality reporting and payment programs should align with the National Quality Strategy (NQS). *The Patient Protection and Affordable Care Act* (ACA) directs the Department of Health and Human Services (HHS) to create an NQS that identifies critically important areas for improvement, sets goals and selects measures to be used in federal programs to encourage achievement of those goals. This plan is meant to set priorities for the health care system as a whole, and relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts. **The AHA strongly supports the premise of the NQS—that is, our nation's health care system can be improved by focusing on aspects of care that a broad array of stakeholders believes to be important.**

To further promote focus and alignment around priorities, we have recommended that the HHS Secretary identify three to five specific priority conditions or issues for measurement each year and implement them through CMS's programs. The expected changes in care should extend across all appropriate providers, and the strategies for improvement, measures used and incentives offered should encourage all to work toward improved outcomes.

The ACA established multi-stakeholder groups that are well positioned to identify priorities and select appropriate measures. The top priority improvement areas can be identified using the National Priorities Partnership. CMS should then identify measures for each of its quality reporting and payment programs that address those priorities areas, and have them reviewed by the MAP before they are included in programs. The AHA has offered specific principles for identifying the right priority conditions and measures each year.

PROGRAMS SHOULD USE RIGOROUS QUALITY MEASURES APPROPRIATE TO POST-ACUTE CARE SETTINGS

Post-acute providers recognize the importance of working on health care system-wide quality improvement priorities. However, each provider along the continuum contributes to an overall improvement goal in a different way. For example, while a hospital's role in improving heart attack outcomes is to provide acute interventions (e.g., surgery), an inpatient rehabilitation facility's work will be oriented toward restoring daily activities and functions (e.g., ability to walk). For that reason, while overall quality improvement goals may be the same, the measures used in each care setting may need to differ to account for the different goals of care in each setting, as well as differences in data collection processes.

Thus, any quality reporting and payment programs for post-acute providers must use measures that are important to the goals of the care being provided and are specified and tested for the care setting they assess. To enforce this standard, Congress should require CMS to use measures endorsed by NQF for the care setting in which they are used. Measures also should be reviewed by the MAP before they are proposed for use in programs. This will help to ensure that the performance of post-acute providers is accurately and fairly assessed.

Unfortunately, CMS has included measures in post-acute quality reporting programs that do not meet these standards. For instance, CMS recently finalized several measures for the Long-Term Care Hospital Quality Reporting (LTCHQR) that have yet to be fully tested or specified for use in long-term care hospitals (LTCHs). One of these measures assesses the proportion of patients experiencing one or more major falls with injury. We agree that reducing patient falls is an important goal requiring interventions in multiple care settings. However, the measure's specifications must be shown to obtain accurate results in LTCHs. In this case, the measure's NQF-endorsed testing results and specifications are specific to nursing homes.

We believe that CMS intends to achieve alignment of purpose by taking measures used in reporting programs for one setting and including them in another. However, this practice

compromises the accuracy and credibility of measure results, making it difficult to determine whether improvements are being realized.

We also believe that the practice of using measures for one care setting and applying them to another without adequate specification and testing may stem from gaps in the available measures for post-acute care. For instance, post-acute providers urgently need measures of patient functional status, goal attainment, care coordination and cost that would allow them to engage with broader, cross-health care system improvement priorities. **As post-acute quality reporting and penalty programs are expanded, we recommend support for targeted measure development efforts to address these gaps in post-acute quality measurement.** In some cases, measure for one care setting may simply need to have their technical specifications updated to align with the data collection capabilities of a post-acute facility. Other gap areas—particularly care coordination—may require the development of new measures.

PAY-FOR-PERFORMANCE PROGRAMS FOR POST-ACUTE CARE

Our nation's health care delivery system is in transition as reimbursement moves from a volume-based methodology to one based on value and quality. Linking provider reimbursement to meeting quality benchmarks has the potential to align the health care delivery system toward continuous quality improvement, and provide financial rewards to providers that demonstrate achievement. **However, pay-for-performance programs must use measures that accurately assess provider performance, and incentive structures that challenge providers to improve while rewarding them for progress.**

Pay-for-Performance Program Principles. To date, there has been considerable variation in the design of federal pay-for-performance programs. Some, such as the Hospital Value-based Purchasing (VBP) Program, assess multiple aspects of care delivery, weighting some areas higher than others. The VBP program also is structured to give hospitals incentive payments based on their performance, both versus their own baselines and national benchmarks. By contrast, programs such as the Hospital Readmissions Reduction Program assess one aspect of care and are payment penalty programs, with only downside risk for comparatively low performance.

In general, the AHA favors pay-for-performance programs that assess multiple aspects of care, and that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance. The inclusion of multiple aspects of care within one pay-for-performance program provides a consistent evaluation mechanism and incentive structure, reducing confusion about how performance is evaluated. We also believe this incentive structure provides greater inducement for providers to improve performance.

The AHA believes that measures should be added to post-acute care pay-for-performance programs in a gradual, step-wise process. This will ensure that programs assess performance accurately, and address issues of high priority. Our guidelines are as follows:

- Measures implemented in federal programs should be reviewed and endorsed by the NQF prior to inclusion in a federal program to ensure that each measure is important, scientifically sound, useable and feasible to collect.

- Federal programs should require that measures being considered for inclusion be reviewed by the MAP before they are formally proposed in rulemaking. As noted in the previous section, the MAP's review should be informed by overall health care system priorities, thereby allowing an assessment of whether measures support improvement in the most important areas.

- Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year. In this manner, the results can be monitored to be sure that there is variation in performance; the causes for variation can be identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments can be made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.

- Monitoring of a measure's performance should continue throughout its use in a pay-for-performance program. When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs. This will create room for identification of additional improvement opportunities and inclusion of new measures.

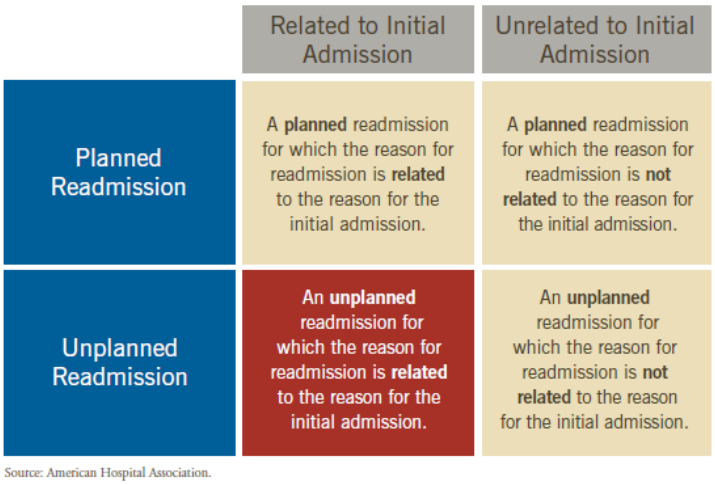
READMISSIONS REDUCTION

The AHA believes that identifying and reducing avoidable readmissions—including those related to post-acute care—has the potential to improve patient safety, enhance coordination of care across settings, and reduce health care spending. The experience of the field to date suggests that readmissions reduction requires participation from, and collaboration among, all providers—acute care hospitals, post-acute care providers and physicians—as well as the patients and communities they serve. However, the field is still learning exactly what combinations of interventions are most likely to result in reduced readmissions. It is also not yet clear what performance measures are most likely to induce the health care field to reduce readmissions. As policymakers contemplate readmission pay-for-performance programs for post-acute providers, we offer the following guidance to inform their design and implementation.

Focus on Preventable Readmissions. Several years ago, the AHA, in consultation with clinicians, developed a framework (Figure 1) to help policymakers and providers consider the different types of readmissions. This framework was developed to inform acute care hospital readmission reduction policies, and we believe it is also applicable to post-acute care. While some readmissions might have been avoided if the patient received the right care at the right time, still others may be unavoidable due to the natural progression of disease, accepted treatment protocol, or a patient's preferences. Some readmissions are part of a planned course of

treatment. This framework can aid policymakers in designing a program for reducing readmissions that targets those re-hospitalizations that are less desirable and potentially avoidable.

Figure 1: A Framework for Classification of Readmissions



Source: American Hospital Association.

The framework contemplates four distinct types of readmissions:

1) A planned readmission related to the initial admission, such as a series of chemotherapy treatments or reconstructive surgery following removal of a body part.
2) A planned readmission unrelated to the initial admission, such as readmission for removal of a lung tumor discovered during an admission for a heart attack.
3) An unplanned readmission unrelated to the initial admission, such as readmission for a fracture sustained in a car accident following an initial stay for an appendectomy.
4) An unplanned readmission related to the initial admission, such as readmission for a surgical site infection or adverse reaction to a medication.

It is this last group of readmissions—those unplanned but related to the initial admission—on which AHA seeks to focus public policy efforts to reduce readmissions. Providers have limited ability to influence the occurrence of unplanned, unrelated readmissions because they are neither predictable nor preventable. Likewise, hospitals ought not to be expected to eliminate planned readmissions, as these are typically part of clinically appropriate treatment plans.

Structuring Readmissions Measurement. We believe the goal of expanding readmissions pay-for-performance efforts to include post-acute settings is to hold more parts of the system accountable for coordinating care, thereby inducing reductions in readmissions. **However, readmissions measurement must be carefully structured to help, and not hinder, collaboration across the system.** As noted above, the health care field is still learning what configurations of care interventions among multiple parts of the system are most likely to reduce readmissions. As measures and financial incentives for reducing readmissions are added for post-acute settings, policymakers will need to carefully balance accountability for performance

across the system. For example, given the differences in duration and goals of care across acute and post-acute settings, policymakers will need to consider what measurement timeframe is most likely to provide the greatest incentive for the system to improve. It will also be crucial that the measures created for each setting of care must be specified, tested and NQF-endorsed for use in that setting to ensure the measures accurately reflect each provider's performance.

Risk Adjustment. Regardless of the setting of care, readmissions measures should be appropriately adjusted for factors beyond an organization's control. We believe that the severity of patient illness and co-morbid conditions must be part of measure risk adjustment models. As noted above, the measures should also be adjusted to ensure they focus on unplanned readmissions related to the initial reason for hospitalization. **We have continually urged CMS to exclude unrelated readmissions from calculating acute-care hospital readmissions because we do not believe such readmissions reflect the quality of care provided.**

As additional readmissions measures are developed for post-acute care settings, we strongly urge Congress to direct CMS to adjust the readmission rates for differences in socioeconomic status before determining if a provider has "excess" readmissions. Based on early experience with the acute-care hospital readmissions penalty program, it has become clear that those hospitals that serve poorer communities have a much greater challenge in trying to reduce readmissions. This is true because preventing readmissions does not depend solely on the actions of the hospitals. For patients to continue to improve and be able to stay out of the hospital, they need access to medications, appropriate food, primary care clinicians and other vital resources, but these resources are often less readily available in low-income communities.

Hospitals are part of the community of providers that helps to fill in these gaps; however, it is both unfair and counterproductive for large readmission penalties to be leveraged against the providers serving these communities. We believe such penalties take away resources these hospitals could be using to help bolster the flagging health system in their communities. MedPAC intends to further explore the role that socioeconomic factors play in readmissions. We believe any lessons learned from this examination should be applied to measurement of post-acute provider readmissions.

Readmissions Incentive Structure. As with all pay-for-performance programs, we believe that an effective readmissions reduction program would recognize all providers for both achievement versus national benchmarks and improvement versus their own baseline performance.

To the extent that payment penalties are assessed for excess readmissions, they should be proportionate to the costs of excess readmissions. Payment penalties have the potential to focus attention on readmissions and to generate cost savings. However, we also believe that savings will be realized by reducing readmissions, and not solely from penalties. For that reason, we caution against using a payment penalty formula similar to that of acute-care hospitals. Indeed, the Medicare Payment Advisory Commission (MedPAC) determined that the flawed formula penalizes hospitals approximately five times more than they were paid for those excess

readmissions. Instead of levying excessively high penalties, Congress should ensure that penalty programs recognize the savings generated both by payment penalties and by reduced readmissions. We believe this step would create fairer programs that better engage the provider community.

Lastly, any payment incentive or penalty formula must be structured to provide a long-term incentive for hospitals to make improvements. Unfortunately, experience with the acute hospital readmissions reduction program suggests that the program's penalty formula actually punishes hospitals for making improvements. MedPAC finds that the payment penalty is inversely related to the national readmissions rate for each condition. Thus, as readmission rates drop across the nation, the magnitude of the penalty grows. Instead, providers should be rewarded for the field's overall progress in reducing readmissions so that the long-term goal of the program can be realized—that is, real reductions in readmissions that mean better care for patients at lower costs.

POST-ACUTE ASSESSMENT INSTRUMENTS

The CMS-developed patient assessment instrument for post-acute care, the Continuity Assessment Record and Evaluation (CARE) Tool, has been the subject of much interest among policymakers and post-acute care providers. The purpose of the tool, which the AHA fully supports, is to establish common metrics for collecting consistent data on the clinical status and health resources provided to patients in all of the post-acute settings—home health agencies (HHA), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and LTCHs. But while the underlying concept for the tool is still widely supported, the actual CARE Tool has been criticized for a variety of reasons, including for being too lengthy, time consuming and failing to capture the clinical complexity and medical resources needed to treat sicker patients, such as those treated in LTCHs.

CMS initially presented the CARE Tool as a future replacement for the existing post-acute assessment tools used by HHAs, SNFs and IRFs. However, more recently, CMS has confirmed that such replacement is no longer the goal for the CARE Tool. Instead, as a far less ambitious goal, CMS is using *elements* of the CARE Tool for post-acute quality reporting and, as CMS noted in a 2012 report to Congress, the agency may use distinct items from the tool to augment the existing post-acute assessment instruments to promote comparability of data.

AHA members participating in CMS's Center for Medicare & Medicaid Innovation (the Innovation Center) bundling demonstration Models 2 and 3 report that in spring 2013, CMS shared a streamlined version of the CARE Tool, called the B-CARE Tool, with them. Of the four bundling models being tested in this demonstration, Models 2 and 3 involve post-acute care providers. Model 2 involves approximately 50 groups of general acute care hospitals, physicians and post-acute providers, while Model 3 is being tested by 13 post-acute only groups. Bundlers also report that the Innovation Center is mandating that participants in Models 2 and 3 use the B-CARE Tool during the "at-risk" stage of the demonstration, which commences on either Oct. 1, 2013, or Jan. 1, 2014, under the two allowed timeframes. While CMS has not yet conducted training on the B-CARE Tool, bundlers are planning to use the tool in addition to other patient

clinical assessments needed for patient care planning, mandatory Medicare quality reporting, and to collect information needed for Medicare claims submission and annual cost reporting.

While we are encouraged that CMS, through the Innovation Center, is not requiring bundlers to use the full-scale CARE Tool, we encourage policy makers to look beyond the B-CARE tool to other post-acute assessment instrument models that have emerged in recent years. The AHA has identified several provider-developed discharge tools that are being used by private payers and hospitals to provide decision support for discharges from general acute-care hospitals. We support the use of an appropriately designed, common assessment instrument. And we encourage CMS to use the bundling demonstration to test a variety of assessment tools applicable to all post-acute settings. The AHA is exploring the content and use of various tools and their application to the Medicare population.

BUNDLED PAYMENT

The CMS bundling demonstration mandated by the ACA will soon complete its first stage, with organizations in the demonstration currently preparing to move to the next stage, where they will begin to face financial risk. This is the only large-scale bundling project to date that includes post-acute care providers; therefore, this demonstration is an important opportunity to acquire a great deal of information on the clinical, operational and financial considerations of bundling post-acute services. **Given this new opportunity for learning, the AHA encourages the Innovation Center to share early lessons with the broader provider community.** This would provide invaluable lessons to other provider organizations preparing for future delivery system reforms toward episode payment. In particular, we encourage CMS to provide forums to allow organizations in the bundling demonstration to share with the broader provider community lessons from their bundling design process and initial stages of bundling, rather than wait until the conclusion of the demonstration to share findings.

Lessons on Design and Management of the Bundle:

- How were bundled conditions selected?
- What are the key payment specifications? For example, how are disproportionate share, teaching and other payment adjusters, as well as high-cost outlier payments handled? Were transfer cases excluded?
- How is cross-setting episode management done?
    - Does the bundling partnership manage the patient under one plan of care?
    - Were HIPAA confidentiality requirements amended to facilitate information sharing among bundling partners?
    - Were regulations pertaining to patient transitions from one setting to another waived? If not, how did the bundlers work with these requirements?
- How are cost targets set?
- How are communication, operations and clinical decision making managed among the bundling partners?
- How are cost, clinical and quality data collected, analyzed and shared with bundling partners and CMS?

- How did cross-setting medical staff design and implement new clinical protocols for bundled conditions?

Lessons on Post-Acute Considerations:

- How did the bundling convener identify and select post-acute partners?
    - What data metrics were used to assess potential post-acute partners?
    - What were the attributes of stronger post-acute partners?
    - What were indicators of weaker partners?
- What are lessons learned for contracts between the convener and post-acute partners?
- Do post-acute partners need certain IT capacity?
- What criteria do hospitals in the bundling partnership use to decide whether to hold a patient longer vs. refer to a post-acute setting?
    - What criteria are used to select which post-acute setting will receive the discharging patient?
- Were some bundling conditions targeted for reduced post-acute services by the convener?
- How was the post-acute portion of the bundled payment determined by the convener?
- What value do post-acute providers contribute to the overall bundling effort?

The long-term goal of Medicare delivery system reform would benefit by sharing these early experiences with the broader provider community on an ongoing basis, instead of waiting for the completion of these programs.

Regulatory Waivers to Improve Clinical Integration. Today, large-scale efforts to experiment with bundling programs are concentrated in the Innovation Center's bundling demonstration**.** Participants in the demonstration report that the Innovation Center has recognized the importance of reducing the extensive regulatory barriers that prevent developing improved ways to integrate clinical services provided by more than one setting, and improve transitions across settings. For example, it appears that Model 2 bundlers have received a waiver of the SNF three-day stay requirement, as long as bundled patients are referred to a SNF with at least a three-star (out of five) rating. In addition, Model 2 and 3 bundlers will receive payment for one homecare visit per 30 days for homebound beneficiaries—a slight coverage expansion—which will support important assessments of a beneficiary's home environment to identify clinical and support services to facilitate successful transitions home. **The AHA supports the Innovation Center's initial waivers of post-acute regulations. However, to optimize the lessons learned through the demonstration, it is important for CMS to continue to expand the initial regulatory waivers approved thus far. Doing so will allow bundlers the freedom to design and test new care pathways without excessive constraints. We have gone on record on numerous occasions and with multiple policy makers to stress the need for regulatory waivers for the items listed in Attachment B, which are critical to optimize the re-tooling of cross-setting care coordination and new clinical pathways needed to improve quality and reduce costs.**

Discouraging Stinting on Medically Necessary Post-Acute Care. At this early stage of the bundling demonstration, it remains unclear how bundled payments will affect post-acute care.

We anticipate that, to create new efficiencies, some bundlers will experiment with re-tooling current clinical pathways. This is a highly complex undertaking that must be carefully planned and assessed to determine which new pathways generate true clinical and efficiency gains, while preserving access to medically necessary care, including post-acute care services. As an example of the complexity of this exercise, the treatment of DRG 470 (major joint replacement without major complications and comorbidities) currently follows more than 2,000 clinical pathways during a 30-day hospital/post-acute episode. These pathways include extensive variation in the sequence and types of providers that treat DRG 470 patients during a 30-day period. The AHA is concerned that bundlers attempting to retool clinical pathways for common post-acute conditions such as DRG 470 may lack comprehensive knowledge of post-acute care and will be challenged by the dearth of comparative literature on the relative merit of post-acute settings and treatment options. Given these limitations, we are concerned that bundlers may over-rely on cost considerations and may stint on medically necessary post-acute care when determining how to re-tool the post-acute portion of clinical pathways, rather than also weighing quality considerations for the episode of care, which may reduce access to medically appropriate post-acute treatments. **CMS must take steps to develop episode quality measures that discourage bundlers from stinting on medically necessary care.**

To discourage stinting during this period of pathway refinement, Medicare must pair bundling with quality measures for the episode of care in order to study comparative outcomes for existing and new cross-setting pathways. Such examinations will require compatible outcomes measures that cross settings, as well as cover the full episode of care. Episode measures must cover a period that includes services provided by all post-acute settings—longer than 30-days following discharge from a general acute care hospital—to include periods of care provided to HHA and LTCH patients. Measures that cross settings and cover longer episodes for conditions targeted by bundlers will be an essential control to discourage bundlers from simply reducing post-acute services and/or transitioning patients with medical needs that can only be met by a general acute care hospital or hospital-level post-acute setting (such as an IRF or LTCH) to less-costly settings.

As such, we encourage Congress to take steps to ensure that longer episode lengths are tested and to accelerate the development of quality measures that cover an entire episode of care. Such episode quality measures could then be coupled with episode of care cost measures such as the acute myocardial infarction 30-day episode-of-care payment measure in development (see our January 2013 AHA comment letter). While the AHA did not support the recent addition of this measure to the Hospital Inpatient Quality Reporting Program, it may have merit in the context of bundled payment programs.

Support Post-Acute Providers in Preparing for Episode Payment. Early bundling and shared savings innovators have taken important first steps to assess approaches to generate care improvements and overall savings—a complex undertaking. However, most providers, including many post-acute care providers, are not equipped to begin these assessment and planning processes, which involve significant up-front investments and capabilities that many providers lack. **We encourage CMS to consider ways to support providers outside of the formal programs run by The Innovation Center to evaluate their readiness for future reforms, such as episode payment, using readiness benchmarks identified through the**

formal programs. In addition, sharing key data to providers outside of the formal innovation initiatives, such as, market and provider-level episode cost and readmissions data, would help the broader provider community begin to identify opportunities for improvement and take basic steps to begin to prepare for future reforms. Such data may also help post-acute develop approaches to improve care transitions.

Beneficiary Choice. The ACA does not allow restructuring of Medicare benefits or cost sharing under the shared savings or bundling programs. Yet, for these initiatives to be effective, we encourage Congress to consider new ways to allow providers to attract beneficiaries to these provider partnerships, which aim to improve care and reduce costs. For example, following a model used in a pre-ACA demonstration, CMS could allow providers to offer reduced cost-sharing to beneficiaries who agree to receive care from providers deemed by CMS as "high-quality providers." As another example, Congress could grant CMS the authority to waive the hospital discharge condition of participation (CoP) that prohibits recommending specific sources of post-acute care to beneficiaries. Doing so would aid bundlers and accountable care organizations (ACOs) in demonstrating to patients why it would be advantageous to stay within the bundling or ACO network where all providers participate in a common quality improvement process.

SITE-NEUTRAL PAYMENTS

There are two post-acute care site-neutral policy concepts under consideration by policy makers—IRF-SNF site-neutral payment and inpatient prospective payment system (PPS)-LTCH PPS site-neutral payment. **The AHA opposes both of these proposals based on the absence of a clear and reliable method to identify clinically similar patients treated in different settings, as discussed further below.**

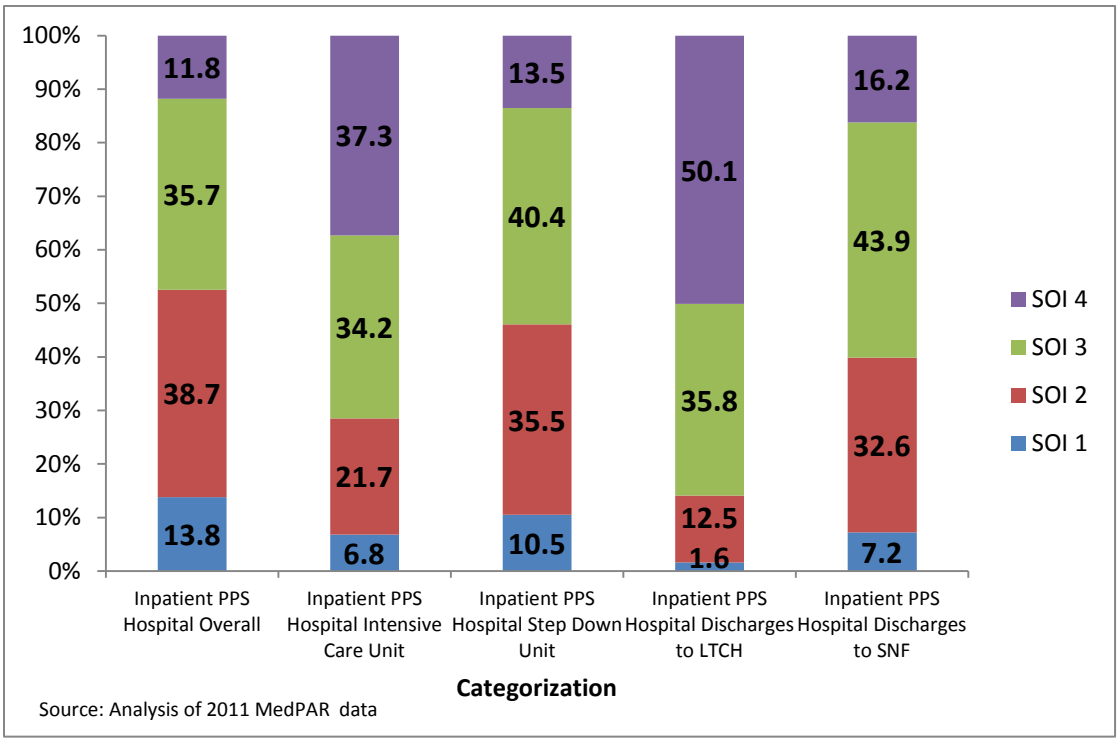
IRF-SNF Site-Neutral Payment. The administration put forth a FY 2013 budget proposal to reduce IRF payments approximately to SNF level for hip and knee conditions, and pulmonary conditions, as well as other conditions selected by the HHS Secretary. The brief explanatory materials that accompany this budget proposal note the intended goal of reducing the disparity in Medicare payments between these settings, but do not provide any detailed specifications.

Inpatient PPS-LTCH PPS Site-Neutral Payment. A second post-acute site-neutral payment proposal pertains to the subset of LTCH patients that CMS believes do not warrant an LTCH-level payment, and should instead be paid under the inpatient PPS. The AHA found that, under CMS's LTCH PPS site-neutral framework, less than 35 percent of LTCH patients would meet CMS's new "chronically critically ill" (CCI) criteria, which would be required for LTCH-level payment. The remaining non-CCI patients—more than 65 percent of the LTCH patient population—would be paid under the inpatient PPS.

As discussed in our June 2013 comment letter to CMS (pages 2 through 7), the agency's CCI proposal raises serious concerns. First, CMS's research overlooks the unique role played by LTCHs. Specifically, LTCH patients have more complex care needs than the average patient in general acute-care hospitals. They have an average length of stay, 27.2 days, that is significantly

longer than that of patients in general acute-care hospitals, 5.1 days, or even intensive care unit (ICU) patients in general acute-care hospitals, 6.7 days. In addition, LTCHs have a pronounced focus on treating patients with the highest level of severity of illness, which is unmatched by other hospital settings, including the ICU as shown in the figure below. For example, 86 percent of inpatient PPS patients discharged to LTCHs have the highest a severity of illness (SOI) – level 3 or 4. In contrast, only 72 percent of inpatient PPS patients in the ICU and 54 percent of inpatient PPS patients in step-down units have an SOI of three or four.

Figure 2: Case Mix, by Severity of Illness (SOI), for Different Categorizations



Another top concern with CMS's CCI proposal is that it does not appear to be a reliable identifier of more severely ill patients. We conducted analysis based on the proposal's requirement that CCI cases have at least eight days of ICU services in the prior stay in a general acute-care hospital. In studying this ICU metric, we found that for some MS-LTC-DRGs, patients with eight or more ICU days do not appear to be materially clinically distinct from those using fewer ICU days. Specifically, for the data shown below on common LTCH conditions, patients had similar numbers of MS-LTC-DRG complications and comorbidities or major complications and comorbidities (CC/MCC) and similar LTCH lengths of stay, regardless of whether they received more or less than eight days of ICU services. This finding is based on the limited description of CMS's CCI analysis that the agency has shared thus far.

Figure 3: Comparison of LTCH Patient Characteristics by ICU Days for Selected MS-LTC-DRGs

2011 SAF Data Selected DRGs from analysis of LTCH cases referred from IPPS hospital within 24 hours	**MS-LTC-DRG 871** Septicemia Or Severe Sepsis W/O MV 96+ Hours W MCC		**MS-LTC-DRG 004** Trach w MV 96+ or PDX exc face, mouth & neck w/o major O.R.		**MS-LTC-DRG 189** Pulmonary Edema & Respiratory Failure	
	ICU <= 8 days	ICU = 8+ days	ICU <= 8 days	ICU = 8+ days	ICU <= 8 days	ICU = 8+ days
Average No. of CC/MCCs	5.7	6.7	9.3	9.3	4.6	5.3
Length of Stay in LTCH	22.9	22.3	49.2	47.7	20.7	22.2
% of Cases in MS-LTC-DRG	69%	31%	38%	62%	47%	53%

Next Steps for Site-Neutral Payment. It is clear to the AHA that neither of these post-acute site-neutral proposals is appropriate for implementation. However, it is also clear that policymakers are appropriately concerned about potential payment differentials generated by treating clinically-equivalent patients in different post-acute settings. Policy-makers addressing this concern need a method to identify clinically-equivalent patients and, on a condition-specific basis, identify the costs associated with providing medically necessary services, regardless of setting. Such information would be valuable in determining how to treat patients in the right setting at the right time.

To make a concrete advance toward quantifying and then mitigating this differential in a responsible manner, policymakers need a reliable method to accurately identify clinically similar patients, which is necessary before accurate and meaningful cross-site comparisons can be made. This comparative methodology would need to consider multiple metrics such as diagnosis, functional status, the subset of complications and comorbidities that contribute to greater medical resource needs (using a methodology similar to comorbidity tiers of the IRF PPS and inpatient/LTCH PPS MS-DRG systems), and perhaps others, such as non-clinical factors like socio-economic indicators. This framework could then be used to conduct apples-to-apples comparisons of the cost of treating similar patients in different settings, which should take into account costs over an episode of time, including avoidable readmissions. Given the broad interest in moving toward more efficient payment systems, it would be appropriate for Congress

to fund research to accurately and reliably identify clinically similar patients who are treated in more than one setting. Without this tool, policymakers designing a site-neutral model are left to rely on assumptions and estimations when identifying the conditions and settings that are suitable for site-neutral payment.

Proposal to Raise Minimum Standards for LTCHs. While much exciting work is underway that will eventually allow policymakers to implement a new payment paradigm for Medicare, CMS also continues its work to improve each of the post-acute payment systems. Such interim refinements are an appropriate concurrent activity to the agency's work on longer-term improvements for the overall healthcare system. In a similar fashion, AHA supports an interim LTCH proposal over CMS's site-neutral CCI approach. The AHA-supported legislative proposal would implement minimum admissions standards to further distinguish LTCHs from other settings by preventing the admission of patients with low acuity and those medically suitable for admission to an IRF, inpatient psychiatric facility or other setting. We encourage Congressional and CMS support of this or a similar approach to identify the patients who benefit from LTCH services, rather than relying upon CMS's arbitrary and ineffective ICU metric.

ATTACHMENT B

Regulatory Barriers to Care Coordination & Improvement

The American Hospital Association (AHA) has gone on record many times citing the various laws that act as barriers to seamless clinical integration. Among the larger list of barriers, a subset applies to bundled payment. **Without removal or significant modification to these barriers, the full potential of bundling payment cannot be assessed.** The barriers included below are not an exhaustive list of every barrier that may need to be removed for all delivery system reform programs. Rather, this list of barriers and needed waivers was created specific to bundled payments. The list of waivers we are requesting responds directly to the level of risk and accountability that the Centers for Medicare & Medicaid Services (CMS) is asking providers to assume when accepting a bundled payment, with bundled payment shifting a portion of the burden of risk further from the Medicare program onto providers. **In our willingness to take on more risk and accountability under a bundled payment, hospitals and post-acute providers expect CMS to be willing to waive these barriers that were designed for a fee-for-service (FFS) environment and are counterproductive to clinical integration.**

We encourage CMS and all of our members to pursue a comprehensive review of all potential barriers, beyond those listed the table below. **In addition, we urge CMS to grant waiver of the barriers in the table below to all bundled payment participants.**

Barriers to Post-Acute Care and Other Barriers	**Regulation**
Admission Decisions	
Prior 3-day inpatient stay for skilled-nursing facility (SNF) services	42 CFR §409.31
Inpatient rehabilitation facility (IRF) 60 percent rule	42 CFR §412.622
IRF 3-hour therapy rule	Benefits Policy Manual, Pub. 100-02, ch.1 §110.4.3
Long-term care hospital (LTCH) 25 percent rule	42 CFR §412.541
LTCH average length of stay rule	42 CFR §412.534
Transfers among co-located providers	42 CFR §412.532
Hospital within hospital transfers	42 CFR §412.532

Assessment Tools	
IRF patient assessment instrument (PAI)	42 C.F.R. §412.614
SNF minimum data set (MDS)	Provider Reimbursement Manual, Pub. 15-1, Ch. 28, 2832
Home health agency (HHA) outcome and assessment information set (OASIS)	42 CFR §484.55
Care Plans	
Psychiatric hospitals	42 CFR §482.61(c)
Physician and eligible professional office setting	42 CFR §485.711
SNFs and nursing facilities (NFs)	42 CFR §483.10(d) and 483.20(k)
HHAs	42 CFR §484.10(c) and 484.18(a)(b)
Hospice	42 CFR §418.56(b)-(d)
Discharge Planning	
Acute inpatient hospitals	42 CFR §482.43
Psychiatric hospitals	42 CFR §482.61(e)
SNFs and NFs	42 CFR §483.12(a), 483.20(l) and 483.20(o)
Hospice	42 CFR §418.26
Patient Confidentiality	
Acute inpatient hospitals	42 CFR §482.13(d) and 482.24(b)(3)
Physician and eligible professional office settings	42 CFR §485.721(a)
SNFs and NFs	42 CFR §483.10(e)(2)-(3) and 483.75(l)(4)
Ambulatory Surgical Centers	42 CFR §416.50(d)
HHA	42 CFR §484.11, and 484.48(b)
Hospice	42 CFR §418.52(c)(5) and 418.104(c)

Beneficiary Inducements	
Anti-kickback	1128B(b)(1)
Civil monetary penalties (CMP)	1128A(a)(5)
Legal Barriers	
Anti-kickback	1128B(b)(1) and (2)
CMP	1128A(b)(1) and (2)
Stark	1877(a)

Admission Decisions. We urge CMS to allow bundled payment providers waiver of several regulations that restrict flexibility of admissions decision-making. Since bundled payment participants will be taking on the risk of managing patient care, the decision to admit a patient to a setting of care should solely be at the discretion of the bundling participant. Currently, admission screening requirements inhibit the efficient movement of patients through an integrated delivery system and limit the ability to determine where and how patients should be treated. We urge CMS to allow applicants waiver of the following:

- Mandatory three-day stay in an acute inpatient facility prior to covering SNF services;
- Restrictive list of diagnosis codes limiting full reimbursement for IRFs (60 Percent Rule);
- Requiring patients to complete a minimum of three -hours of therapy per day for IRF eligibility;
- Prohibitions for transfers between co-located providers (25 Percent Rule for LTCHs);
- Requiring a minimum average length of stay for LTCH eligibility;
- Hospital within hospital transfers;
- Required face-to-face encounter with a physician prior to initiating home health services; and
- Requiring multiple physicians (managing and hospice) to certify that the patient meets Medicare criteria for hospice services.

Assessment Tools. We urge CMS to allow bundled payment providers waiver of submission of patient assessment tools. In most post-acute care settings, CMS requires submission of assessment tools. These tools are used, in part, to justify the need for utilizing post-acute care services. With bundled payments, the decision on how to manage a patient's care will be at the sole discretion of the provider. This will obviate the need for any assessment tools. We urge CMS to allow applicants waiver of the following:

- IRF patient assessment instrument;
- SNF minimum data set; and
- home health agency outcome and assessment information set

Beyond using assessment tools to justify the need for services, assessment tools also may serve other functions, such as being the vehicle through which to submit data for the purpose of calculating quality measures. By waiving the requirement of assessment tools, CMS may not receive the quality measure data required under existing programs for any beneficiaries in a bundled payment arrangement. However, we see this as an opportunity for CMS to explore new and innovative ways to measure the quality of services provided in a bundle. **Specifically, rather than recycling existing quality measures to assess care delivered in a bundle, we urge CMS to consider new measures that better align with the comprehensive package of services contained in a bundle**. Each bundle may contain a very different collection of services and, therefore, may require a unique set of quality metrics.

Plans of Care. Rather than require a separate care plan for each setting of care, we urge CMS to waive this requirement for bundled payment providers and instead allow for one care plan for all services provided under the bundle. In the inpatient acute hospital conditions of participation (CoP) proposed regulation, CMS proposes to remove the requirement for a care plan to be established for each different department within a hospital. The proposal would allow for a central interdisciplinary plan of care, rather than requiring separate care plans per discipline (nursing, respiratory care, occupational therapy and pharmacy). We commend CMS for recognizing that this existing hospital CoP is a barrier to integration, and we urge CMS to waive the following additional care plan requirements for services delivered under a bundle:

- Psychiatric hospitals;
- SNFs and nursing facilities;
- HHAs; and
- Hospice.

Discharge Planning. We urge CMS to allow bundled payment providers waiver of post-discharge planning restrictions. There are several regulations regarding discharge or transfer that inhibit the efficient movement of patients through an integrated system. In order to maximize the benefits of an integrated system, limitations on the patient's right to choose among providers may be appropriate. When a patient elects to receive a bundle of services from a provider, that patient is also electing to receive a carefully prescribed course of treatment, which can span multiple provider settings. Providers managing a bundle of care must be given the flexibility to direct patients to the next setting of care that is appropriate. That flexibility should include guiding patients into a post-discharge setting that the bundling provider feels most comfortable with. There are several regulations built into the CoPs that preclude this flexibility. We urge CMS to allow bundle payment providers waiver of the following post-discharge restrictions:

- Providing patients discharged from a general acute hospital to home care with a list of all home care providers in the area; and
- Providing a detailed hospital discharge summary prior to admission to a psychiatric facility, SNF, NF and hospice.

Patient Confidentiality Rights. With the publication of comprehensive standards for health information privacy and security mandated by the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 and expanded under the *Health Information Technology for Economic and Clinical Health Act*, CMS no longer must rely on the CoP standards for medical records confidentiality to ensure effective protections for patient medical information. The general statements contained in the CoP do not consider the broad scope of appropriate uses and disclosures of patient medical information by providers, including those participating in any delivery system reform initiative such as a bundled payment arrangement. They also do not offer the specificity necessary for participants in such arrangements to effectively fulfill their objectives of simultaneously delivering high-quality patient care in the most cost-effective manner – the intended purpose of a bundled payment arrangement − while protecting the confidentiality of patient medical information. In fact, CMS's interpretations of the CoP provisions directly contradict guidance about HIPAA privacy and security implementation issued by the Office for Civil Rights (OCR). The conflicting interpretations create confusion for all Medicare providers, including those participants in a bundling payment arrangement, and interfere with effective protections for confidentiality and security of patient information. While not without their own complications and barriers to the successful operation of clinically integrated arrangements, the HIPAA standards, not the CoP provisions, provide the appropriate basis for protecting patient medical information without inhibiting the coordination of patient care, including in the specific circumstances of bundled payment participation. **We recommend that CMS eliminate the CoP obligations for medical records confidentiality for providers, including those participating in CMS's bundled payment arrangements. Instead, CMS should rely on and defer to OCR's interpretation, oversight and enforcement of the compliance obligations under the HIPAA privacy and security standards.**

Beneficiary Inducements. CMS, in partnership with the Office of the Inspector General (OIG), has recently made great strides in addressing many of the barriers in place around beneficiary inducements. In the Accountable Care Organization (ACO) interim final regulation with comment (IFC) on waivers, CMS and OIG stated the following:

> This IFC promulgates a waiver of the Federal anti-kickback statute and Beneficiary Inducements CMP to address arrangements pursuant to which ACOs, ACO participants, and ACO providers/suppliers provide beneficiaries with free or below-fair market value items and services that advance the goals of preventive care, adherence to treatment, drug, or follow-up care regimes, or management of a chronic disease. This waiver will help ACOs foster patient engagement in improving quality and lowering costs for Medicare beneficiaries by removing any perceived obstacles… (76 FR 68007).

We strongly urge CMS and OIG to offer the same beneficiary inducement waiver package to all bundled payment participants.

Legal Barriers. In addition to waiver of the beneficiary inducement prohibitions, the CMS and OIG ACO IFC also created waivers of the physician self-referral (STARK), anti-kickback and gainsharing CMP laws for ACOs in three circumstances: 1) pre-participation, 2) participation,

and 3) shared savings distribution. **We strongly urge CMS and the OIG to offer all of the ACO waivers to all bundled payment participants. The shared savings distribution waiver should be adapted to create a "savings distribution" waiver for all bundled payment participants.**