



**American Hospital
Association**

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May 12, 2014

The Honorable Ron Wyden
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 Wyden, 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 weigh in on the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 discussion draft. Below we outline our primary concerns with and recommendations for the draft language. We look forward to seeing the next version of the language.

COMMENTS ON PROPOSED IPPS/CAH/CANCER HOSPITAL REQUIREMENTS

Our members have significant concerns about the feasibility and burden of collecting the proposed patient assessment data. For example, it is likely that the data would need to be collected through a combination of both electronic health records (EHRs) and manual chart abstraction. Our members expressed little confidence that they could rely solely on an EHR to collect the data. They also expressed concerns about how the data would be used outside of post-acute payment reform efforts. **For these reasons, we recommend that the reporting requirements for hospitals be removed from the legislation.**



COMMENTS ON PROPOSED POST-ACUTE CARE (PAC) QUALITY MEASUREMENT AND PATIENT ASSESSMENT REQUIREMENTS

The post-acute provisions in the IMPACT language include numerous positive elements. First, we appreciate that the collection of standardized patient assessment data and consistent quality measures mandated in the draft legislation has the potential to build an infrastructure that facilitates future system-wide and post-acute reforms. We also strongly agree with the IMPACT Act's approach of not mandating a single patient assessment tool for all post-acute providers, as we believe such a mandate is premature. Further, we value IMPACT's acknowledgment that developing a common platform for post-acute reporting is complex and will require time, and the thoughtful timeframe that was developed to phase-in the multiple elements in IMPACT.

Concerns Regarding Data Comparisons Across PAC Settings. One of the goals of the data collection mandated by the IMPACT Act is to inform the design of post-acute payments structured around patient conditions, as opposed to specific care settings. While we share the goal of a more integrative approach to meeting the needs of post-acute patients, comparing data from multiple PAC settings is a difficult undertaking since, among other reasons, each PAC setting treats a different mix of patients and offers distinct services. The following brief list of examples illustrates this point:

- Inpatient rehabilitation facilities (IRFs) provide physician-led care in combination with three hours of therapy per day. This combination of services is not provided in other PAC settings.
- Long-term care hospitals (LTCHs) treat a population with dramatically higher acuity levels than the other PAC settings. They also uniquely provide ventilator weaning services, at times in combination with other services such as end-stage renal disease (ESRD) services, that other settings do not.
- Under the *Jimmo vs. Sebelius* ruling, home health agencies (HHAs) and skilled nursing facilities (SNFs) are allowed to treat patients to prevent or slow further deterioration, in a departure from the medical necessity standard used for the other PAC settings (demonstration of potential for improvement or restoration).
- HHAs provide services in the home, which introduces a unique set of variables that are outside of the monitoring and control of the provider.

Risk Adjustment is Critical. Given the important differences in patient mix, treatment goals and services among PAC providers articulated above, we recommend that risk adjustment be made a central design element of the important infrastructure being built by the IMPACT Act. Risk adjustment is an important tool that helps account for key differences in clinical risk factors (e.g., age, co-morbid conditions, severity of illness) when one is seeking to isolate and compare the quality of care. To date, risk adjustment approaches have facilitated comparisons of providers within a given care setting. However, far less is known about using risk adjustment to compare outcomes of care across different care settings.

Staff indicated to the AHA that there is no intent for data collected under IMPACT to be used for cross-setting quality of care comparisons. We concur with this position, due to the current difficulty in achieving meaningful comparisons of cross-setting services and outcomes.

Therefore, IMPACT should focus on creating the reporting infrastructure that will be needed for future delivery system reforms, and which may be modified in the future to account for future, enhanced data analytical methods on risk adjustment. **In the future, when risk adjustment approaches are improved, policymakers can consider developing and evaluating strategies for cross-setting comparisons. Given current risk adjustment limitations, we recommend that the draft language be modified to explicitly prohibit cross-setting comparisons.**

Therefore, to build toward the future, consideration should be given to expanding the scope of the mandated Department of Health and Human Services (HHS) and Medicare Payment advisory Commission (MedPAC) reports to require further study on risk adjustment across PAC settings.

Incorporate Full Rulemaking. The draft bill's current language (page 20) allows the HHS Secretary to add or remove measures by publishing "in the Federal Register a justification for such removal or addition", with one exception – measures causing significant harm can be removed without following his process. We agree with and appreciate the exception for patient harm. However, we believe that all stakeholders should have the opportunity to assess and provide feedback on measures before they are adopted in programs, as they do with all other federal quality reporting and pay-for-performance programs. Therefore, **we recommend that the IMPACT language be strengthened to require that any removals or additions of measures be subject to public notice and comment through the Federal Register.**

In addition to requiring public notice and comment, IMPACT should require that HHS incorporate input from the provider community through the use of technical expert panels when developing the new PAC assessment requirements and quality measures. The draft language should also be amended to require that the HHS and MedPAC studies incorporate technical expert panels comprised of PAC stakeholders.

Periodically Update the IMPACT Reporting Requirements. While the domains of quality measurement and patient assessment data are intended to reflect the most current needs of the field, quality improvement is a dynamic process. As the field makes progress in some areas, it is appropriate to consider whether the initially mandated domains are still necessary to drive improvement, and whether other areas should be added. Thus, **we recommend that the draft language be modified to require the HHS Secretary to periodically update the measurement domains to revise or replace measurement domains, to account for domains for which providers have achieved compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.** Similar language is in statute for the hospital inpatient quality reporting (IQR) program, and has allowed the Centers for Medicare & Medicaid Services (CMS) to sunset measures no longer of value, and to address new measurement topics.

Integrate the NQF and MAP Process. The bill's current language does not require that new measures under IMPACT be reviewed using the established pre-rulemaking process currently conducted by the National Quality Forum (NQF)-convened Measure Applications Partnership (MAP). The AHA continues to support the multi-stakeholder MAP process, and recommends that the MAP review be made a required step before measures are added to programs.

Minimize Reporting Burden. We appreciate that IMPACT would allow the HHS Secretary to carry out the mandate of the draft bill by utilizing existing PAC data reporting mechanisms. As you know, PAC providers already have a significant and, in some cases, growing reporting burden. For example, the OASIS assessment includes 100+ items and commonly requires two to two-and-a-half hours to complete. To alleviate further unwarranted expansion of this burden, **the draft language should more explicitly require the HHS Secretary to first rely on existing assessment instruments and other reporting as vehicles for implementing IMPACT-related reporting, before considering other new reporting processes. IMPACT also should require periodic reconciliation of PAC data reporting requirements under this bill, the silo-specific quality reporting programs and other mandatory data collection for payment.**

Prohibit Using IMPACT Data for Post-Acute Placement. Since further research is needed on the risk adjustment approaches that are critical for reliable and meaningful cross-setting comparisons, **safeguards must be added to IMPACT to ensure the PAC assessment and quality data collected under the bill are not used to determine placement of patients transitioning from one setting to another.** Developing a reliable process to use these data to support physicians' decision-making related to post-acute placements will be an important step for policymakers and providers to pursue once the IMPACT reporting infrastructure is in place.

Preserve Critical Role of Physician Judgment. The bill should specify that PAC data collected under IMPACT should not limit the role of physician judgment in being a dominant factor in determining post-acute care placement decisions.

Reverse Sequencing of PAC Assessment and PAC QM. The timing of the roll-out of the PAC assessment data (October 2018) and the new PAC quality measures (Oct 2016) should be reversed to allow policymakers to benefit from the new assessment data when designing the new PAC quality measures.

Inconsistent Reporting Requirements Under IMPACT and PAC Payment Systems. Staff should consider how the new data collected under IMPACT may present unintended difficulties for providers who will still face quality reporting requirements (MDS, OASIS, IRF-PAI) that are linked to the respective PAC prospective payment systems. For example, if new measures for functional status and improvements are implemented under IMPACT, and are inconsistent with the specifications of the IRF-PAI functional measures used to determine payment under the IRF payment system, providers will face the challenge of submitting two sets of distinct but similar functional measures. This could mean that therapists and nurses in IRFs will have to assess each patient twice using inconsistent metrics and scales, which is incredibly burdensome and raises the potential for confusion and erroneous reporting. We recommend that the MedPAC and HHS studies be required to examine the burden and related consequences of this inconsistency and to make recommendations on how to mitigate this challenge.

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If you have any questions, please feel free to contact me or 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