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Kathryn Martin
Acting Assistant Secretary for
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Room 415F
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Dear Mr. Slavitt and Ms. Martin,

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including 3,300 post-acute care members – this letter conveys the interest of the American Hospital Association (AHA) to engage in and provide feedback on the work that the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Planning and Evaluation (ASPE) are undertaking to develop a unified post-acute care prospective payment system. Our post-acute membership includes 271 long-term care hospitals (LTCH), 1,115 inpatient rehabilitation facilities (IRF), 847 skilled-nursing facilities (SNF), and 1,100 hospital-based home health (HH) agencies. The pending CMS and ASPE work to build a common payment system for these four settings, as mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), is of great interest to them and to the AHA and we wish to participate to the greatest extent possible.

We note that the CMS/ASPE-led stage of IMPACT's broader policy-development mandate is a complex, multi-year undertaking. As such, at this point we make no assumptions about the outcome of this research and the new payment model. Knowing that, ultimately, Congress will decide whether and how to respond to the 2023 final result of this lengthy research effort, AHA is committed to being an informed stakeholder and constructive partner throughout the full process.

At this early stage in the process, we urge CMS and ASPE to consider the attached principles that reflect our priorities and concerns regarding both the policy development process and the policy content associated with this complex project. These principles were developed under the guidance of the AHA's Post-acute Care Strategy Steering Committee with the goal of aiding in

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the development of a system that supports accurate payment and broad access to high-quality care for Medicare beneficiaries. As such, we seek opportunities to engage with CMS and ASPE staff so that we may become and remain apprised of the overall policy development plan and its progress.

Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org.

Sincerely,

Tom Nickels
Executive Vice President

Recommended Policy Principles For Developing a New Post-Acute Care Prospective Payment System

As CMS and ASPE launch research on a post-acute care PPS model, the American Hospital Association recommends that the following policy principles be considered. These principles acknowledge the complexity of building a payment model that covers such a wide array of clinical conditions and needs. We believe they will provide constructive guidance as CMS, ASPE and other stakeholders evaluate the new model through its multiple stages of development.

- 1. Transparency with stakeholders is critical.** As policymakers and stakeholders proceed with the multi-year process to create a post-acute care PPS model to present to Congress in 2023, it is imperative that CMS and ASPE actively engage in sharing their work in a regular manner. Underscoring the importance of improved transparency, the underlying MedPAC analyses on a post-acute care PPS were not fully shared prior to their June report to Congress. Due to this delayed release, stakeholders lacked the information needed to pose a full array of informed questions during the policy development process. Further, the lack of advance notice and comprehensive sharing of the data and methodologies prevented stakeholders from duplicating and validating this research prior to its submission to Congress. The pending post-acute care PPS development process presents an opportunity for maximum transparency with stakeholders, which will be needed to optimize the scope and value of feedback from the provider community. To begin, we urge CMS and ASPE to share with the AHA and other stakeholders their overall game-plan, key elements of the work plan, and timeframe for post-acute care PPS development. In addition, proactive and timely sharing of the key data and analyses will enable stakeholders, whenever possible, to model the new payment system, while it is under development, and build the knowledge base that will enable the AHA and others to understand the feasibility of a new model and provide meaningful feedback.
- 2. Ensure accurate payment policies, especially for medically-complex patients.** Policies that pay accurately for high-cost/high-risk utilizers will be critical to ensuring access to medically necessary post-acute services. MedPAC's work on the prototype included extensive testing to ensure accurate predictions of the cost of treating medically-complex subgroups of patients. Duplicating this effort during the pending policy development stage will be of equally high importance. Accurate payments for costly patients is especially important for low-volume providers, including many post-acute care providers, who face disproportionate risk medically-complex, expensive patients for whom payment may not cover the cost of essential resources.
- 3. Strengthen risk adjustments for new payment models.** The emerging payment model that pays according to patient characteristics, rather than by care setting, requires extensive risk adjustment to account fully for the numerous factors that affect spending and are beyond providers' control. Such factors include severity of illness and co-morbid conditions. Given their widely acknowledged limitations, if current risk adjustment approaches are used in the next generation of payment models, Medicare would inappropriately penalize post-acute care providers treating the sickest, most complicated and most vulnerable patients.

4. **Clinical assessments of patients transitioning to post-acute care must be accurate, reliable and administratively feasible.** The MedPAC prototype appears to suggest that, under the post-acute care PPS methodology, patient placement decisions and payments would be based, in part, upon patient assessment information collected as a patient transitions to post-acute care, and may include data from the prior hospital stay. In upcoming months and years, CMS will design the post-acute care PPS patient assessment processes to identify patients who will receive post-acute care and help set the payment for that care. These fundamental elements of the payment system must reflect the evidence-based metrics that are specifically tested for use with post-acute services and patients.

In addition, the Commission used all-patient refined-diagnosis related group (APR-DRG) severity of illness data to help predict the cost of care under its prototype. It is possible that CMS would use these data to help design the payment categories, and/or to assign payment under the post-acute care PPS. However, 3M, the developer of the APR-DRG data, has cautioned against relying on these data for post-acute care clinical decision-making: “[a]lthough APR-DRGs are effective for predicting inpatient resource utilization, they were sometimes judged to be too heterogeneous to be directly used as the basis for defining post-discharge care.” As CMS moves forward with the development of these core components of a post-acute care PPS, we urge the agency to ensure that the data used to design the system and assign payment are appropriate, reliable and accurate.

It is also important that all patient assessment requirements associated with any future post-acute care PPS be administratively manageable. In light of the ongoing expansion of post-acute care reporting requirements under the IMPACT Act, wherever possible, new post-acute care PPS reporting requirements should be paired with the elimination of outdated and redundant requirements. In addition, it is critical that the overall quality measurement program limit administrative burden to balance both functionality and value.

5. **Enhance regulatory relief.** The development of a single payment system for the four post-acute care settings presents a unique opportunity for meaningful regulatory relief. As CMS has done when testing and implementing other alternative payment models, the transition to a new post-acute care PPS should be paired with a significantly lighter regulatory load, as the current regulatory framework for post-acute care admissions is substantial and would serve no purpose under the new model. We strongly agree with MedPAC’s recommendation that the new PPS be accompanied by waiving selected setting-specific regulations, and recommend that policies such as the following be phased out under the post-acute care PPS:

- LTCH “25% Rule” and 25+ day average length of stay requirement;
- IRF “60% Rule” and 3-hour rule;
- SNF 3-day stay requirement;
- HH homebound requirement; and
- Other policies designed to distinguish the post-acute settings from one another or to direct post-acute patients to a particular setting.

Since, under the MedPAC prototype, post-acute care would be provided in two settings: 1) institutional post-acute care; and 2) home-based post-acute care, these legacy regulations would serve no purpose and should be rescinded.

6. **Streamline and focus quality measurement.** Quality reporting and pay-for-performance can be effective tools for rewarding high-value care. However, any measure requirements must be streamlined and concentrated on defined, cross-continuum national priority areas. To this end, the AHA supports adopting the recommendations to streamline and focus the national quality measurement efforts outlined in the IOM's recent *Vital Signs* report. Moreover, measures should be as administratively simple to collect and report as possible, and the measure results must be actionable. Lastly, measures should be rigorously risk adjusted for any clinical and sociodemographic factors that are beyond the control of providers and influence performance.
7. **Improve Hospital-to-Post-acute Care transitions.** Developing a new payment system for post-acute care presents an important opportunity to improve transitions of care from hospitals and other settings to a post-acute setting. Therefore, CMS and ASPE should include examination of how the new PPS would impact and could improve these transitions and the related policies that also influence decision-making on a patient's care following hospital discharge. Specifically, while patient discharge processes may fall beyond the strictly-defined scope of the post-acute care PPS development mandate, these processes, in combination with the new payment system, would influence decisions on which patients receive post-acute care and the nature of that care.
8. **Identify upfront infrastructure development costs.** A significant number of post-acute care providers may not have the necessary funds to develop their organizational infrastructure to comply with the new post-acute care PPS model, such as costs associated with meaningful connectivity with local hospital and other key partners. Additional support for providers and vendors may be needed to achieve the type of connectivity that actually improves care for patients treated in a post-acute care setting.
9. **Gather data from all payers.** The population of beneficiaries covered by Medicare Advantage is increasing as a percent of total patients receiving post-acute care. In addition, a growing number of beneficiaries are receiving post-acute care services through alternative payment models. As such, post-acute care PPS policymakers need to remain aware of utilization, cost and outcome patterns under the legacy post-acute care payment systems, Medicare Advantage, any new post-acute care PPS, *and* other alternative models pertaining to post-acute care. These multi-payor, comparative data can provide insights and inform policy developments striving to improve post-acute clinical and operational protocols.