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March 29, 2017

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W. Suite 701
Washington, DC 20001

Dear Dr. Crosson:

The Medicare Payment Advisory Commission (MedPAC) will vote next month on a recommendation that Congress both accelerate the timeline for the development of a unified post-acute care prospective payment system (PAC PPS), as mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and authorize the implementation of such a payment system. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, which include more than 3,000 PAC providers, as well as our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – the American Hospital Association (AHA) wishes to comment on this recommendation.

We appreciate the thoughtful work MedPAC has completed thus far on PAC PPS issues. However, we urge that, prior to voting on its recommendation, the Commission collect more information about the feasibility and advisability of removing five or more years from the statutory timeline for creating and operationalizing a new payment system. We are concerned that such an aggressive move may reduce the reliability and accuracy of the final model, which could result in significant mis-payment and, as a result, harm access to care, particularly for high-acuity patients who use specialized post-acute services that are not provided in all of the PAC settings. Specifically, MedPAC staff projected during the March meeting that, under the IMPACT Act timeline, the earliest a PAC PPS proposal is likely to be presented to Congress is 2024. The draft recommendation under consideration would truncate this timeline by authorizing the implementation of a PAC PPS by 2021, which staff estimated would require the introduction of a proposal to Congress in 2018 or 2019. Yet, the design, testing and validation of this PPS have only just begun under the leadership of the Centers for Medicare & Medicaid Services (CMS) and Assistant Secretary for Planning and Evaluation (ASPE). To complete this process, CMS and ASPE will need to engage in extensive analyses, including:

- Ensuring that the model is transparently shared and can be replicated by stakeholders at key developmental points, as well as prior to finalizing the proposal.



- Collecting, selecting and preparing the relevant datasets (including those derived from patient assessment instruments) needed to comprehensively build out the parameters for the payment model. Given the extensive utilization of data from the Post-Acute Care Payment Reform Demonstration throughout MedPAC's prototype development process, and the widely acknowledged limitations of these data, it is likely that other sources of cost data, such as cost reports, would be needed to design and maintain a full PAC PPS.
- Considering alternatives to the MedPAC prototype's reliance on a complicated regression to assign each patient's payment, such as payment categories based on diagnosis, as found in the inpatient PPS and other payment systems.
- Setting the payment system's degree of complexity to a level that enables annual updating by CMS – a level that the MedPAC prototype did *not* achieve, as it includes a far greater number of variables than a typical payment system.
- Running numerous iterations of the model to evaluate its assumptions, in order to:
 - estimate costs;
 - identify explanatory variables at both the patient and facility-level;
 - estimate the coefficients; and
 - apply the coefficients to calculate payments.
- Determining payment policies for outliers, higher-cost patients and any other special types of cases (for example, short stay, deaths, transfers, patients who left against medical advice, etc.).
- Testing the financial and operational impact of various transition policies, including its length, blended payment amounts and the option to bypass the transition.
- Calculating payment-to-cost ratios.
- Conducting analyses to determine whether the model is reliable, accurate, fair, budget-neutral, stable, preserves access to care for medically-complex patients and provides the correct incentives to providers to provide quality care.

In addition to designing, testing, and validating the PAC PPS, CMS and ASPE will need to develop a regulatory framework. For example, under the MedPAC prototype, the new payment system would include a two-setting model (institutional and home-based PAC providers), replacing the current four-setting model (home health agencies, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and long-term care hospitals). Such a transformation to the PAC regulations and provider infrastructure would require extensive policy work, including:

- Establishing parameters to define one or more lengths of a PAC stay.
- Developing new risk-adjustment and outlier policies.

- Developing payment adjustments and quality metrics to ensure access and high-quality care for high-acuity PAC patients.
- Ensuring that a PAC PPS is based upon a patient-centered quality framework that considers both quality of care and cost outcomes achieved during and after their PAC stays, in addition to process and short-term outcome measures.
- Confirming which post-acute fee-for-service regulations and statutory provisions would need to be waived, rescinded or repealed to align with a PAC PPS.
- Considering how to treat rural and low-volume providers.
- Considering how to adjust payments for teaching, disproportionate share and rural providers.
- Creating combined patient assessment, quality reporting, readmissions and pay-for-performance systems.
- Establishing new conditions of participation for the two-setting model, including both core requirements and narrow requirements for providers of specialized programs.
- Incorporating state licensure, certificate of need and other necessary state-level regulatory changes.
- Establishing systems to discourage stinting on care, unnecessary utilization and cherry-picking of patients.

As a point of comparison, CMS recently invested in approximately three years of work to develop a re-tooled payment system for the SNF PPS. This policy development process is still underway and has not yet allocated the additional time and resources needed to redesign the companion regulations required to execute such a transformation, such as refinements to the SNF patient assessment instrument, provider training on altered claims and quality programs, and other adjustments.

It is unclear which steps would be accelerated, condensed or skipped altogether in order to achieve the timeline included in MedPAC's draft recommendation. The question of how CMS and ASPE could do so without sacrificing the reliability and accuracy of outcomes was only briefly touched upon during the March meeting. **Prior to a vote by the Commissioners, these missing details should be explored in partnership with CMS and ASPE in order to determine the feasibility of completing this extensive set of policy work in time to enable the introduction of PAC PPS legislative proposal in 2018 or 2019.**

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We appreciate your consideration of these issues. If you have any questions, please feel free to contact me or have a member of your team contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Cc: Mark Miller, Ph.D. MedPAC Commissioners