

February 15, 2019

Melissa Morley, PhD  
Health Care Financing and Payment  
RTI International

***RE: Questions emailed by RTI to the Technical Expert Panel on Developing a Unified Post-acute Care Prospective Payment System***

Dear Ms. Morley:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the questions you submitted to the participants of the September 2018 technical expert panel (TEP) on developing a unified post-acute care (PAC) prospective payment system (PPS). Our letter strives to provide constructive input as the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services' Office of the Assistant Secretary for Planning & Evaluation (ASPE) develop a PAC PPS model as required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). This PAC PPS model is being built in conjunction with RTI International and is to be submitted to Congress in 2022. A Medicare Payment Advisory Commission (MedPAC) version of the model will be submitted to Congress in 2023.

**The IMPACT Act requires the design of a model that could replace the four existing Medicare PAC payment systems with one unified system. This is an unprecedented and exceedingly complex policy development endeavor.** It is with the broad scope of this project in mind that we submit comments on our overarching concerns related to PAC PPS development, as well as our responses to RTI's specific questions.

**The AHA appreciated participating in the September 2018 TEP. Given the complexity of the IMPACT Act mandate we encourage the convening of a second TEP once the CMS/ASPE model begins to take form. Regular and timely communication with stakeholders will be essential to producing a model that best serves the full range of patients requiring PAC services.**



## **PRIORITIES FOR BUILDING A PAC PPS MODEL**

**Payment Accuracy.** To be successful, any new PAC PPS must accurately cover the cost of providing PAC services. Any underpayment of certain services would lead to access problems, which is of particular concern for medically-complex patients who have already faced challenges under the current PAC payment systems.

The PAC PPS Baseline Must Reflect 2020 PAC Reforms. All four sectors of the PAC field have transformative changes in process or on the horizon:

- Long-term care hospitals' (LTCH) site-neutral policy began implementation in October 2015;
- A redesigned skilled nursing facility (SNF) PPS will be implemented in October 2019;
- A redesigned home health (HH) PPS will be implemented in January 2020; and
- Major reforms to the inpatient rehabilitation facility (IRF) PPS will be implemented in October 2019.

Each of these reforms is expected to change referral patterns to and from each PAC setting and the scope of services provided by each. Nationally, these shifts have the potential to materially alter aggregate PAC volume and the average cost of care for many conditions. Operationally, providers may struggle to adapt to a fundamentally different paradigm that reforms protocols for staffing, clinical treatments, reporting, budgeting and other management processes – all of which may be more difficult for smaller PAC providers with fewer resources. To illustrate the magnitude of these reforms, we can look to the 2015 through 2020 implementation of LTCH site-neutral payment, which AHA estimates will reduce aggregate Medicare payments by more than \$1 billion from fiscal years 2016 through 2019, and, per MedPAC, yielded a -2.2 percent Medicare margin in 2017.

**To pay accurately, the PAC PPS must use baseline data that reflect this major shift for LTCHs, as well as the remaining PAC reforms to be launched in 2020.** If the CMS/ASPE model fails to use these relevant data as its foundation, we anticipate that it would not accurately capture the resource needs of the full continuum of PAC patients in a way that yields fair and accurate payment. In addition, PAC PPS data would need regular updates to account for subsequent shifts in PAC patient services – by type, cost and volume – which could continue for years due to the magnitude of these reforms.

Concerns with PAC Payment Reform Demonstration (PRD)-derived Data Reliability. While we lack details pertaining to the design of the CMS/ASPE model, based on the design of the MedPAC PAC PPS prototype submitted to Congress in 2016, it is possible that CMS/ASPE may base certain considerations – like case mix groupings or risk adjustment – on existing standardized patient assessment data elements. Specifically, CMS may elect to use the Section GG functional status data elements that were

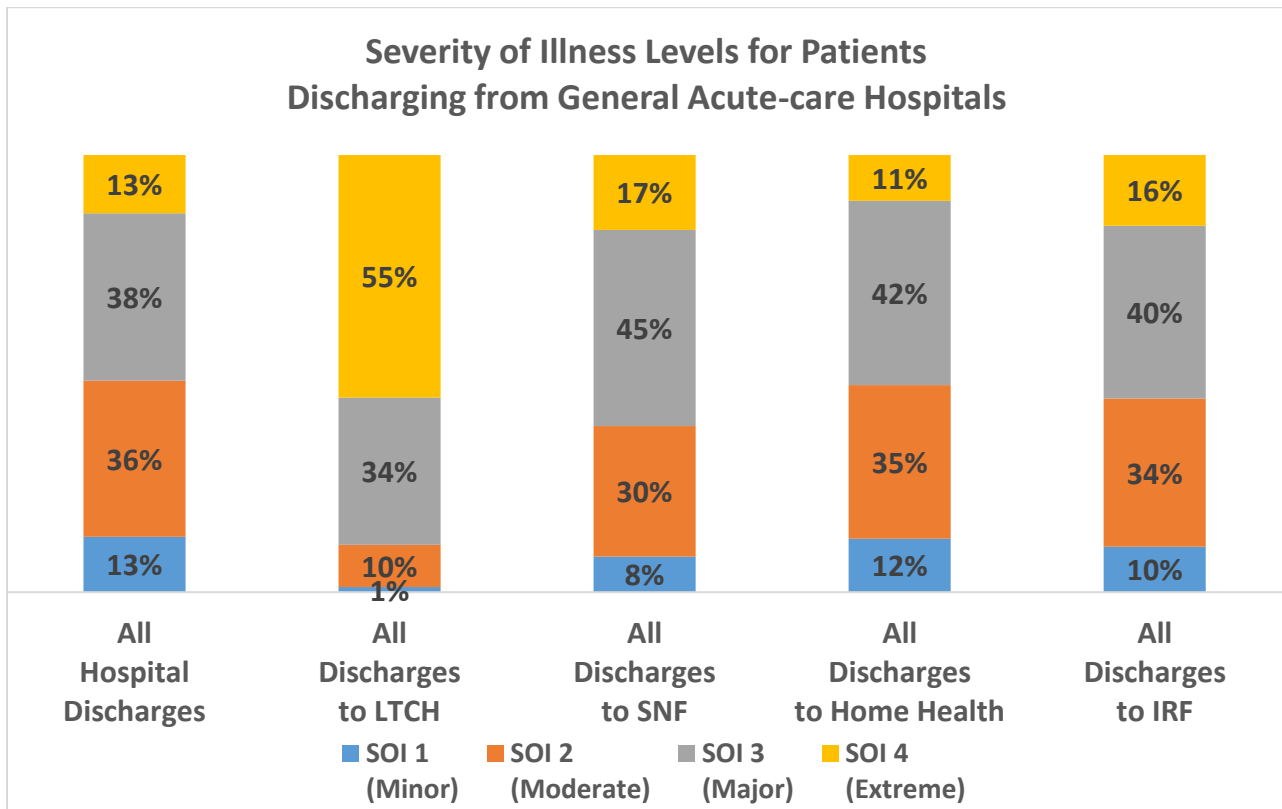
developed as part of the continuity assessment record and evaluation (CARE) item set (as these items were recently finalized in the IRF PPS to inform case mix groups, and are currently among a limited number of data elements used in all four PAC settings). **However, we are concerned about the reliance on these data, which were last tested for reliability and validity during the PAC PRD.**

First, as we have raised in detailed [reports](#) in the past, we question any reliance on the PAC PRD analyses, especially for use in payment determinations. The data used in that analysis are now out-of-date, were limited in scope, and do not reflect the current state of the PAC field in terms of patient volume or distribution across the four PAC settings. For example, the provider sample used in the PAC PRD accounted for just 0.4 percent of PAC providers and 0.1 percent of PAC stays across the four settings in 2013, with SNF and HH providers and stays being under represented. If a PAC PPS was to base payments on case mix groups informed by data elements developed decades ago, it certainly would be misaligned.

Further, we remain concerned about the accuracy of the Section GG patient assessment data elements. First, the elements, which emerged from the CARE tool, have been criticized for their inability to capture the full resource needs of high-acuity PAC patients. In addition, while CMS contends that “elements in the CARE tool include proven predictors of health care costs and utilization,” CMS actually demonstrated only interrater reliability and validity in estimating clinical functional status for the entire tool – a proxy for testing the validity of individual data elements. As a result, policymakers and stakeholders possess little information on the construct validity of each the Section GG functional status data elements in predicting costs and utilization. In fact, we lack any validation of the predictive power of each Section GG item. Given this fundamental limitation, the AHA has called upon CMS to use instead patient assessment data elements that have either been more recently developed and tested for validity in predicting costs and utilization or existing elements for which updated testing—with more recent data—has been performed.

CMS/ASPE Model Must Capture the Resource Needs of the Full Array of PAC Patients. Building a single payment system for a wide array of clinical conditions and acuity levels is a difficult undertaking. In fact, MedPAC has acknowledged this challenge when noting that its PAC PPS prototype does not account fully for the cost of treating the most severely ill PAC patients. Similarly, it was widely acknowledged that the current HH and SNF payment systems were not providing adequate resources for medically-complex cases, which led to access challenges, and, ultimately, CMS’s reform of these payment systems to, beginning in 2020, shift resources to more acute patients.

To demonstrate the range of acuity levels found across the four PAC settings, and therefore the challenge of a unified system accurately capturing the complexity and resource needs of this broad array, we share severity of illness data for general acute-care hospital patients in 2017, based on the PAC setting to which they were discharged.



Source: FY 2017 National MedPAR data, CMS; 3M™ Core Grouping Software, 3M Health Information Systems, Inc.

Thus far, stakeholders are on standby for details on how the CMS/ASPE model would accommodate the full diaspora of PAC patients shown above. In fact, the 2017 Dobson-DaVanzo report on the MedPAC prototype PAC PPS found that “it is likely that not all LTCH or IRF patients can be appropriately treated in lower cost settings.” **As such, it is essential that CMS and ASPE ensure that their model accurately reimburses the cost of treating the full continuum of current PAC patients to avoid access challenges for those with greatest medical complexity and cost.**

**Strong Risk Adjustment is Essential. To avoid a distorted PAC PPS that systematically underpays for certain services, the model would need strong risk adjustment.** Such adjustments are needed to compensate for the limitation of claims and patient assessment data used to set an initial payment, but that often do not convey the full resource needs of a patient, such as external factors outside of a provider’s control. In particular, the AHA recommends that any design and risk adjustment methodology take patient sociodemographic status (SDS) into account.

To assist in the development of this important component of a PAC PPS, the AHA launched research in late 2018 to identify the risk adjustment methodologies that have been used for PAC, their efficacy, and recommendations on how a risk adjustment

methodologies should be incorporated in a PAC PPS model. The findings of this research will be shared with RTI, as well as CMS and ASPE.

**Transparency. Transparency for PAC PPS development is essential.** As such, we reiterate a priority item from the [PAC PPS Guiding Principles](#) submitted by AHA's PAC Steering Committee to ASPE and CMS in Nov 2016:

*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.*

**Any PAC PPS Proposal Should Include a Comprehensive Regulatory Package. The AHA does not support MedPAC's piecemeal PAC PPS rollout approach.** While the Commission has not shared an explicit timeline, it has discussed first implementing the unified payment system in place of the existing PPSs, then, during subsequent years, the PAC PPS accompanying policies. Such accompanying policies include unified PAC conditions of participation (CoP), quality reporting and patient assessments, other related regulations and sub-regulatory guidance, and related state rules, which, collectively, represent substantial policy work and provider preparation, training and cost. Even if a PAC PPS model were to be implemented as the centerpiece of a comprehensive package that includes these accompanying elements, the unprecedented shift from the current four-settings would be a monumental undertaking that would strain both policymakers and providers. Stretching out this exercise by adding elements of the regulatory framework over several years would exacerbate the confusion and workload for providers required to simultaneously operate under elements of the old and new paradigms. We believe CMS may feel likewise, as the agency used this rationale to support its decision to implement in 2020 the redesigned HH and SNF PPS during a one-year transition, rather than through a multi-year phase-in, with very little opposition from providers.

**Implement any PAC PPS in a Budget-neutral Manner.** If in the future, Congress authorizes the implementation of a PAC PPS, the new model should be implemented in a budget-neutral manner. Any behavioral adjustments made to ensure an overall budget-neutral implementation should be made in subsequent years based on data from under the new model. This approach would help avoid incorrect assumptions by the agency on how provider behavior would change under a new model – a problem that has occurred in the past. The complexity of having four distinct payment systems combined into one – an intricate transition never before attempted – provides additional rationale for CMS to avoid assumptions. For the same reasons, we oppose the MedPAC recommendation to couple the roll-out of a new PAC PPS with an across-the-board cut.

It remains to be seen whether CMS and ASPE will stipulate a behavioral adjustment approach along when they complete their PAC PPS model. However, we note that recent PAC reforms show inconsistency in policymakers' treatment of behavioral adjustments related to major reforms. For example, the recent redesign of the HH and SNF payment systems involved starkly different approaches for their respective behavioral adjustments. Per its authorizing statute, CMS has stated its intention to implement in 2020 both its new HH model *and* a four-part behavioral adjustment based on assumptions of provider behavior shifts under the new model, with subsequent adjustments to follow. In contrast, the new SNF model will be implemented in 2020 with no behavioral adjustment, but an assumption that at least one adjustment will be made in the future.

**First Pilot a PAC PPS Prototype.** Given the unprecedented disruption that would be caused by any future shift to a unified system, it would be essential for the agency to first pilot the model with a representative sample of PAC providers. Indeed, skipping this step likely would lead to a chaotic rollout of a new model. Further, a pilot could provide the opportunity to remedy any problems prior to submitting the model to Congress. However, any pilot should avoid the errors of the PAC PRD, which utilized a provider sample that was skewed and too small, failed to capture the full complexity of high-acuity patients, and relied on a time-study to assess costs that that was executed with inadequate staff training – shortcomings that still influence PAC policy. In other words, piloting the CMS/ASPE PAC PPS model prior to proposing the model to Congress would benefit policymakers, providers and patients. After incorporating lessons from the pilot in the model, CMS and ASPE could then present the most viable version of the model to Congress along with important companion regulatory changes, as discussed below.

**Limit Administrative Burden under a PAC PPS.** Both today and under any new payment model, PAC providers need a manageable administrative burden.

Complexity of Shifting to a PAC PPS. The magnitude of change that a shift to a PAC PPS would require each PAC provider to consider is difficult to overstate. For example, it would entail:

- Payment changes for its existing patient population, and any changes to admission practices to target a new patient mix that could sustain a viable financial profile;
- Shifts in its scope of services, which could alter its role in the local continuum of care;
- Potentially new admission, treatment and coding protocols;
- Changes to workforce quantity and composition;
- Staff training and education on the new payment system and related regulatory and sub-regulatory changes;
- Compliance with new Medicare CoPs;
- Compliance-related changes to state guidelines;
- New reporting requirements; and
- Multiple additional changes.

Collectively, these shifts would produce a new organizational profile that must be evaluated carefully by each organization's board of directors and executive and clinical leadership to determine viability under the new model. It is possible that this evaluation will lead some PAC providers to cease operations.

Keep it Simple. The Dobson-DaVanzo report on the MedPAC prototype identified as a major weakness its reliance on a 100-variable regression model. This approach was found to be far too complex for providers seeking to assess a patient's clinical need for the setting in addition to estimating the associated Medicare payment, a critical step for ensuring quality of care and the long-term viability of the organization. With this complex regression in mind, we urge CMS and ASPE to build a model that is user-friendly, which ultimately also benefits patients and CMS.

A PAC PPS Must be Paired with Regulatory Relief. **A new PAC PPS model must not be combined with current regulations that were designed to address limitations and flaws in today's PAC payment systems.** Specifically, if the new model is capable of setting accurate payments based on patients' clinical characteristics, there will remain no, or a greatly diminished, need for legacy regulations that reflect a prior generation of payment policy. Further, by the time any PAC PPS could be implemented, the individual PAC payment systems will be materially overhauled from the versions that initially prompted policymakers to add these restrictions. In other words, many of the legacy regulations no longer will be warranted after the 2020 reforms are in effect, much less under a potential PAC PPS implementation after 2023. In particular, under a PAC PPS, the following regulations should be rescinded:

- SNF 3-day stay rule;
- LTCH ALOS requirement;
- LTCH site-neutral payment policy;
- IRF 60% Rule;

- IRF 3-hour rule; and
- HH homebound rule.

The examination of these legacy regulations also should include an evaluation of related state regulatory changes needed to align with a new PAC model.

**Structure of the Provider Community under a PAC PPS.** As we have considered the ASPE/CMS PAC PPS development process, one foundational question is how many PAC settings would exist under a PAC PPS of the future. One approach is to use MedPAC's PAC PPS prototype of 2016 as a strawman that provides a baseline from which to contemplate how a PAC PPS actually may operate, as well as RTI's questions addressed below. Specifically, MedPAC's view is that the provider community paid by its 2016 model would consist of two PAC provider types: institutional PAC providers and home-based PAC providers. While the current four-setting framework includes HH agencies, SNFs, IRFs and LTCHs, MedPAC's approach assumes only two because it found HH patients, services and payment were too distinct from those of institutional PAC providers to blend together.

In addition, we are aware of multiple different stakeholder viewpoints on how to structure a PAC PPS provider community, including recommendations to carve out selected segments of the field. As such, we recommend that MedPAC's vision for a particular provider framework not be treated as a foregone conclusion at this early stage. Instead, now is the time for careful contemplation of multiple options by CMS and ASPE.

**MedPAC Recommendation to Expedite PAC PPS Implementation is Unrealistic. The AHA opposes the MedPAC recommendation to expedite PAC PPS implementation to 2021.** Based on the extensive study of the Commission's 2016 prototype by Dobson-DaVanzo, we are confident that PAC PPS implementation is far too complex to undertake without an adequate evidence base. We elaborated on the regulatory steps needed to complete the development of a PAC PPS in our March 2017 letter to [MedPAC](#). Instead, we support the timeline established by the IMPACT Act, which requires CMS to submit a PAC PPS model in 2022 and MedPAC to submit its own model by June of 2023.

**PAC PPS Education for Referral Hospitals.** Any future transition to a PAC PPS must be accompanied by not only comprehensive and timely education and training for PAC providers, but also for their affected partners. A transition of this magnitude would have a ripple effect throughout the continuum of care and would, therefore, require education and training for referring hospitals and other key partners.



## **RESPONSES TO RTI QUESTIONS**

For our responses below, we have modified the sequence of some of RTI's nine questions to group them by topic.

### **1.A. What clinical services should be considered in a unified PAC PPS given the differences in the packages of services included in the current PAC PPSs?**

The CMS/ASPE model should incorporate the full scope of medically-necessary services covered by existing PAC payment systems. This includes a wide range of services, from hospital and intensive care unit (ICU)-level care through home-based therapy and nursing. It will be important to ensure that the model comprehensively accounts for the services required by high-acuity patients. In addition, it would be important to preserve the PAC services that are uniquely provided by one setting during the realignment of services during a transition to a unified PAC PPS model.

However, we recommend focusing on PAC patients' clinical characteristics and needs as a starting point, which will lead to the required scope of services. Building a model that allocates both standard payments and add-on payments according to a patient's acuity level would align with CMS's recognition that sicker patients require additional resources and with some of the most effective features of the existing PAC payment systems. For example:

- The LTCH and IRF PPSs set standard payments according to each patient's diagnosis and procedures;
- The inpatient and LTCH PPSs pay more for patients with complications and comorbidities associated with higher resource needs;
- The IRF PPS pays more for patients with selected comorbidities identified as requiring additional resources;
- Beginning in 2020, the redesigned HH and SNF PPSs will rely on a composite set of clinical and non-clinical patient characteristics to set payments, including adjustments for greater costs. In addition:
  - The SNF PPS will pay extra for non-therapy ancillary services for patients with qualifying function scores;
  - The HH PPS will increase payments for patients with a qualifying comorbidity or blend of comorbidities, functional level, admission source and sequence of the episode of care;
- The SNF PPS applies a 28 percent payment add-on for AIDS patients; and
- The SNF PPS also pays extra, beyond the standard per diem rate, for certain rare and high-cost items, such as chemotherapy drugs, for patients with a qualifying condition.

**1.B. What key payment system components should we include? For example, LTCH payments include nursing, therapy, comprehensive ancillaries, and an interrupted stay policy for acute hospitalizations. In contrast, HH agency**

**payments include nursing, therapy, aide, social work and supplies, but do not include comprehensive ancillaries or an interrupted stay policy for acute hospitalizations.**

High-cost Outlier Policy. To help ensure access for high-acuity, high-cost patients, a high-cost outlier component would be a critical element of any PAC PPS model. This would be of even greater importance under a PAC PPS model similar to the MedPAC prototype, given its acknowledged inability to fully account for the costs of the most severely ill PAC patients. In addition, this adjustment is particularly critical for smaller providers lacking the ability to bear atypically high-cost cases. We note that the SNF PPS lacks a high-cost outlier policy, which is a burden for those providers, such as hospital-based SNFs, treating medically complex and very costly patients.

Non-therapy Ancillary Services. We also support a specific adjustment to cover the cost of comprehensive ancillaries. This would be similar to the SNF PPS refinement in 2020 that will finally include the cost of non-therapy ancillary services (such as radiology, laboratory and IV costs) that are associated with the treatment of medically complex PAC patients. Specifically, the redesigned SNF model will apply a payment add-on for non-therapy ancillary services based on the function score of the patient, with regard to 50 conditions and extended services identified as driving additional resource needs.

Interrupted Stay Policy. In general, we support the inclusion of interrupted stay policies that, following a patient transfer to another setting (for example, if a surgery is needed) for four or more days, treat the returning patient as a new patient. This is a feature of the existing LTCH and IRF payment systems and will be incorporated into the SNF PPS in 2020.

## **2. What period of time should be considered in a unified PAC PPS? Stay? Episode? Period of days? Are there different considerations for inpatient versus HH settings?**

Among other things, the IMPACT Act requires the development of a PAC PPS model that applies to PAC items and services furnished according to patient characteristics rather than according to PAC setting of care, and that furthers clinical integration between hospital systems and PAC providers. The 2016 MedPAC prototype assumes payments would be made on a per-stay basis. During its October 2018 meeting, MedPAC approved a research plan to investigate how the PAC PPS could be designed to issue payments on an episode basis, including by engaging an external partner to manage care coordination. The Commission is expected to share its findings in 2019, which will provide important insights on this issue for RTI and other stakeholders.

The pros and cons of episode versus per-stay payments will require careful analysis of patient characteristics and cost of care. This evaluation must consider the frequent occurrence of patients receiving care from more than one PAC provider within 30-day, 60-day and longer episodes of PAC care. Under an episode arrangement, the AHA

would support each PAC provider being the recipient of Medicare payments for its own services. In addition, an episode approach would require policy development on how care coordination and other services by PAC or partnering physicians and case managers would be compensated – either within or outside of the PAC payment. These incredibly complex questions have not been addressed by MedPAC or other policymakers – which again points to the many unprecedented policy development elements involved in IMPACT’s PAC PPS-development mandate.

We do note that a PPS that blends per-stay and episode policies already exists for PAC providers in all four settings being evaluated with the Medicare spending per beneficiary (MSPB) episode measure. For these PAC settings, MSPB captures services rendered during the 30-day period triggered by the commencement of PAC services and includes any services that follow discharge from first PAC site of care. The goal of the MSPB measure is to encourage collaboration across settings to improve outcomes and manage costs. Perhaps PAC PPS developers may draw useful insights from these providers currently facing external evaluation based on both the care they deliver during the patient stay *as well* as how well they coordinate care before and after the patient stay.

Under any episode arrangement, pairing the payment system with robust outcomes measures is important for discouraging stinting on high cost services, which is a particular concern for high-acuity, high-cost patients.

### **3.A. Should the development of a unified PAC PPS assume today’s utilization and transfer patterns?**

The PAC PPS model presented by CMS and ASPE to Congress should be based on cost, volume and other data that account for the impact of the PAC reforms discussed above. In addition, any behavioral adjustment that would be proposed to accompany a PAC PPS should be based on actual data from providers operating under the new payment system, as discussed above. Further, as discussed below, when determining the resource needs of patients and facilities under a PAC PPS, it is essential to avoid untested assumptions that result in payments being set based on a proxy, rather than actual cost data.

### **3.B. Should the development of a unified PAC PPS assume the provision of multiple levels of care within a single PAC setting (i.e., treatment in place)? What are the pros and cons of each of these approaches for providers and beneficiaries?**

Any proposal to implement a unified PAC PPS should allow flexibility and not mandate the scope of PAC services delivered by a particular provider. Each provider organization should determine its own scope of services, which, at least initially, is likely to reflect its historic areas of expertise. As such, and noting that PAC includes a broad continuum of clinical services, we would anticipate relatively wide variation in the scope of services within the broad group of providers paid under a PAC PPS. In addition, the model

should allow for a single PAC provider to provide a mix of services reflecting multiple points across the continuum of PAC services. This flexibility also would help accommodate the likely evolution over time of providers choosing to expand or contract their scope of PAC services as they adapt to the new model. Finally, we support MedPAC's concept of creating additional criteria and/or certification for those providers that elect to treat high-acuity patient populations under a new PAC PPS. Such minimum standards would ensure that providers have the specialized personnel, equipment, training and other elements required for high quality care for patients with high-acuity conditions.

If beneficiaries receive more than one level of care in a single PAC setting, multiple assessments may be appropriate. For example, a patient who first receives IRF-level services where he undergoes physical therapy following a traumatic brain injury will have new and longer-term goals for his functional independence when he transitions to SNF-level services. Such a patient should be reassessed with the SNF-appropriate patient assessment items, and his functional goals should be considered in comparison to his status when receiving the preceding IRF-level services. We note that under the SNF PPS, multiple patients assessments can occur that, if a qualifying change in clinical status occurs, result in a payment adjustment for subsequent care.

- 4. Is it necessary or desirable to differentiate between beneficiary-specific costs and setting-specific costs in the development of a unified PAC PPS to reduce over or under payment?**
- 7. Are there other setting-specific considerations that a unified PAC PPS should take into account?**

The CMS/ASPE model should differentiate between beneficiary-specific and setting-specific costs and adjust for both. Beneficiary-specific adjustments should be applied for patients with high acuity/high-cost clinical characteristics; facility-specific adjustments should address the additional facility costs necessary when treating high-acuity/high-cost patients.

Beneficiary-specific Costs. CMS and ASPE should consider a variety of ways to cover the extra cost of treating patients who require additional resources due to, for example, their clinical characteristics or rural location. Such extra payments would help ensure the accurate payments needed to help ensure access to care for these beneficiaries who, in many instances, have faced documented access challenges under the current payment systems. In particular, these adjustments should include the items in our response to question 1.A. that pertain to extra services (and therefore costs) for medically-complex patients, as well as:

- A high-cost outlier policy to avoid penalizing those providers who admit and treat sicker PAC patients;

- As will be the case under with the SNF PPS beginning in 2020, make an additional adjustment for patients requiring non-therapy ancillary services associated with medical complexity (such as medications, radiology, IV use).
- Payment add-on for durable medical equipment;
- Consider payment add-ons for patients with characteristics indicative of needing behavioral health or care coordination resources to achieve a successful discharge to community without an avoidable hospital readmission; and
- As is the case with the HH PPS, apply a payment add-on to help cover the cost of accessing beneficiaries in rural homes.

Facility-specific Costs. It would be appropriate for the CMS/ASPE PAC PPS model to account for facility costs such as:

- Compensating personnel in higher-wage geographic areas;
- As is the case with the IRF and inpatient psychiatric facility (IPF) PPS,
  - Treating patients in rural areas;
  - Operating a training program for medical students;
- Operating in high-cost Alaska and Hawaii;
- As with the IPF PPS, operating a qualifying emergency department;
- As under the inpatient and IRF PPS, treating a disproportionate rate of low-income patients, as indicated by dual eligibility for Medicare and Medicaid, or other metric;
- Operating specialized programs for higher-acuity/higher costs patients who would otherwise face challenges accessing PAC care, such as ventilator, wound and/or infectious disease programs, which can require specialized personnel, equipment, training, certification or other condition-specific items; and
- Transitioning to the new regulatory and sub-regulatory framework of the PAC PPS, including compliance with new CoPs and other requirements; infrastructure and personnel modifications, and other transitional costs.

Rely on Timely Cost Data Instead of Assumptions. When determining the resource needs of patients and facilities under a PAC PPS, it is essential to avoid untested assumptions that result in payments being set based on a proxy, rather than actual cost data. The implementation of LTCH site-neutral payment in 2015 provides a cautionary tale regarding incorporating unfounded assumptions into a payment system and, as a result, systematically underpaying a large segment of the patient population. Specifically, CMS assumed that LTCH site-neutral cases would match the acuity and cost profiles of inpatient PPS patients with comparable MS-DRGs. However, actual data clearly show that site-neutral cases are far sicker and required substantially more hospital days and resources than their inpatient PPS comparison group, which has led to payments, under full implementation of the policy, only covering 45 percent of costs, on average – an egregious underpayment.

**5. Analyses looking at unified PAC PPS will include all PAC settings (LTCH, IRF, SNF, and HH agency). Is it also valuable to examine different combinations of settings?**

We encourage CMS and ASPE to consider multiple approaches for organizing services under a PAC PPS. Such exploration would fit with the IMPACT Act mandate, which granted policymakers the autonomy to test various model designs. As such policy development is carried out, we again point to the over-arching importance of payment accuracy for the full range of acuity levels currently treated by the four PAC settings, a PAC PPS baseline that reflects the 2015 and 2020 PAC reforms of the current payment systems, and the application of a the robust risk adjustment to ensure accurate payment for all patients.

**6. What are the implications for assessment data collection if beneficiaries receive more than one level of care in a single PAC setting?**

Because patient assessment data are collected differently depending on where the patient receives care, the data collected is difficult to compare across settings. LTCH and IRF patients are assessed upon admission and discharge, whereas the HH agency patient assessment instrument is administered after admission, discharge, transfer, a significant change in patient condition, and at 60-day recertification; SNF patients are assessed at days 5, 14, 30, 60, and 90 of the SNF stay. In addition, while the various setting-specific patient assessment tools have been updated to include some standardized elements (i.e. each setting now collects some of the same data), there are still unique elements to individual settings, and other settings that do not collect the same information. It is appropriate for each setting to collect different data in some cases, as patients have different functional goals across settings (e.g. LTCHs do not collect information on whether patients can ambulate certain distances, as most LTCH patients are confined to their beds). Therefore, as noted above, if beneficiaries receive more than one level of care in a single PAC setting, multiple assessments may be appropriate.

**8. What quality measures will be important to monitor to ensure quality of care for beneficiaries under a unified PAC PPS? Can these quality measures be used to inform value-based payments in a unified PAC PPS?**

The AHA appreciates that RTI is seeking input specifically on monitoring quality of care under a unified PAC PPS, as any such model would provide a financial incentive to reduce costs while maintaining a safe and effective environment for patients. Additionally, payments must be adequate to ensure that providers can continue to deliver this level of care to beneficiaries. With those general considerations in mind, we encourage RTI and CMS to develop quality and resource use measures individually for hospital-based PAC providers (LTCH and IRF) and monitor them separately from those measures for SNF and HH agencies. Hospital-based providers incur different costs and are held to different expectations in terms of facility safety than are SNF and HH agency

providers, so evaluating quality and resource use based on measures that are developed agnostic of provider type would not yield accurate or reasonable assessments of performance.

Further, we encourage RTI and CMS to continue to uphold the tenets of CMS's Meaningful Measures initiative, and use a streamlined and parsimonious set of quality measures in whatever unified PAC PPS model moves forward. All PAC providers already report on several quality measures, and each new measure requires additional staff time to collect and report data, to train on how to comply with measure requirements, and to update reporting and IT infrastructure. Staff time is finite, so these administrative duties take away from patient care. Any quality measures should focus on areas of highest priority to patients, encourage coordinated care, and assess aspects of care on which providers have control: patient outcomes (particularly functional status) and safety (including healthcare-acquired conditions).

Quality Measures Require Risk Adjustment. A large body of evidence demonstrates that sociodemographic factors, such as income and insurance status, affect many patient outcomes, including readmissions and costs. Sociodemographic adjustment helps assess all providers fairly and accurately on the quality of care they provide and their contribution to patient outcomes while mitigating negative unintended consequences of measurement. Identifying appropriate sociodemographic adjustments also may help to highlight the impact of those factors on patient outcomes, allowing them to be addressed.

Failing to adjust quality measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to worse outcomes. Hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, as the research cited by the expert panel's report demonstrates, there are external factors that contribute to poor outcomes. If quality measures are implemented without identifying those external factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities would be diminished.

Value-based Purchasing (VBP). In general, the AHA favors pay-for-performance programs, such as VBP, that assess multiple aspects of care, and that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance. We believe this incentive structure can provide greater inducement for providers to work collaboratively to continually improve performance. However, we urge CMS to avoid the missteps of other VBP programs, such as overlapping or conflicting quality measures. Similarly, a PAC VBP program should avoid direct comparisons of providers in different settings to determine payouts, i.e.

comparing scores on quality measures for providers in all four settings in a single ranking.

Appropriate quality measures for a VBP program would meaningfully differentiate high-quality and efficient performance by focusing on potentially preventable readmissions or complications (rather than all-cause, as will eventually be used in the SNF VBP program) or other important outcomes that are truly within the control of the provider, rather than only measures on spending. We also encourage CMS to consider composite measures of change in functional status, such as the two composite items on mobility and self-care that were recently implemented in the HH VBP pilot. These composite measures (or measures like them) capture change instead of improvement, which is particularly relevant to the goals of those PAC patients admitted to maintain function and prevent decline, rather than to improve – one of the clinical roles that distinguishes PAC from general acute-care hospitals.

**9. A unified PAC PPS puts an emphasis on patient needs rather than setting of care. What are the design elements of a unified PAC PPS that will help empower patients and their families to work with providers to make care decisions?**

Functional outcomes data can be helpful in engaging with patients and their families, as this type of information is directly related to a patient's longer term goals. Providers can demonstrate what types of functional gains or maintenance can be achieved with the help of clinical care: a patient may be able to live on his/her own for longer, be able to walk certain distances without assistance, or be able to feed and dress him/herself following an episode with a PAC provider. While data on process or structural metrics (e.g. adherence to clinical guidelines or use of health information technology) can be helpful to inform internal operations, this information is confusing and unhelpful to consumers who lack specialized clinical knowledge.

The following steps also could improve the experience of beneficiaries needing PAC services and should be considered:

- As discussed above, incorporate SES in quality measure risk adjustment, which would ensure that payments reflect a more comprehensive profile of patient and family needs;
- Allow both hospitals and PAC providers engaged in discharge planning to provide information to the patient and family regarding higher-quality PAC partners to improve patient experience and outcomes. Granted, the relative concept of "higher-quality" has been used by MedPAC, but its specifications have not been shared with stakeholders. This concept would require thoughtful and transparent policy development conducted through full rulemaking and public comment; and
- Augment PAC payments with an add-on for care coordination to improve patient experience and outcomes.



Ms. Melissa Morley  
February 15, 2019  
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We thank you for your consideration of our comments. 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](mailto:rarchuleta@aha.org) or (202) 626-2320.

Sincerely,

/s/

Ashley B. Thompson  
Senior Vice President  
Public Policy Analysis and Development