

The Issue

The unified post-acute care (PAC) payment system required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 is not on track to protect access to medically necessary PAC services. Rather, the payment system under development disregards the realities of the post-COVID-19 pandemic landscape, and thus will not reflect the actual clinical and resource needs of the modern PAC patient population.

Creating a consolidated payment system that accounts for the medical complexity of the full array of patients treated across the four PAC settings is difficult. In fact, doing so requires taking into account the long-term health care delivery system changes spurred by both the COVID-19 public health emergency (PHE) and the major PAC payment reforms implemented after the IMPACT Act's passage. To this point, as we near the two year anniversary of the PHE, we understand that if it is actually to function in the real world, the new model must facilitate patient access to the services provided by home health (HH) agencies, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs).

The IMPACT Act could not have anticipated the major and sustained influence of COVID-19 and the resulting changes to the overall health care delivery system, including in PAC. However, as we prepare for the post-pandemic landscape, **Congress must take steps to align the new model with these profound changes, if the IMPACT Act's goal to produce a unified PAC payment system is to be meaningfully fulfilled. As such, the AHA continues to strongly urge Congress to pass H.R. 2455, The Reset the IMPACT Act, to yield a PAC Prospective Payment System (PPS) prototype that could function in the post-pandemic environment.**

Resetting the IMPACT Act

Without modifications to the design, the final PAC prototype will not align patients' clinical needs with accurate payments. Resetting the IMPACT Act would help address the following limitations of the model currently being developed.

Lack of a Risk Adjustment Plan is a Major Gap.

A sound risk adjustment approach is needed to accurately match payments with the clinical resources needed by each PAC patient. Unfortunately, because stakeholders still have not seen an actual model, we remain in the dark regarding the projected accuracy and reliability of the under-development model.

Current PAC Value-Based Purchasing (VBP) Advances Have Been Overlooked. Value-based purchasing is needed to help ensure that PAC patient care is of the highest quality. However, stakeholders thus far have been given no insight about how a PAC VBP could be paired with the new payment model. Of particular interest, there are no indications regarding whether recent efforts, such as the HH VBP program that CMS has proposed for national expansion, would influence the operation of the unified payment model to be presented to Congress next year.

Major PAC Reforms Recently Implemented

- **HH Reform.** In January 2020, a reengineered HH payment system was implemented: the patient-driven groupings model, which shifts resources from high-therapy to medically complex patients.
- **SNF Reform.** In October 2019, a completely redesigned payment system was implemented for SNFs: the patient-driven payment model, which shifts resources from high-therapy to medically complex patients.
- **LTCH Reform.** In FY 2021, the LTCH field fully implemented a two-tiered payment model that pays far lower rates for lower-acuity hospital patients, now 1 out of 4 cases. This reform materially reduced overall LTCH payments and volume, and even resulted in LTCH closures.

Real-world Relevance Falls Short. To be suitable for actual implementation after the PHE, the PAC PPS design process itself must incorporate data from the post-PAC payment reform and post-pandemic era. Otherwise, the design of the model will — in great part — reflect out-of-date patient utilization patterns and patient care protocols.

Varied Coding Guidelines Restrict Policy Conclusions. The unified payment system policy work is using inconsistent data definitions to define patients’ clinical characteristics. These core diagnostic definitions and coding guidelines, which differ across the PAC settings, will hinder all aspects of this policy-making process and, in the long- run, diminish the correlation between payments and patients’ medical needs.

No CMS-MedPAC Consensus on How to Capture Patient Clinical Status. When building its PAC payment model, MedPAC intentionally avoids the use of certain provider-reported clinical data (patient assessment and functional status data) because they are viewed as unreliable. However, the CMS-contracted researcher expands upon them in their PAC PPS work. This fundamental contrast should be reconciled prior to recommending a PAC PPS prototype to Congress next year.

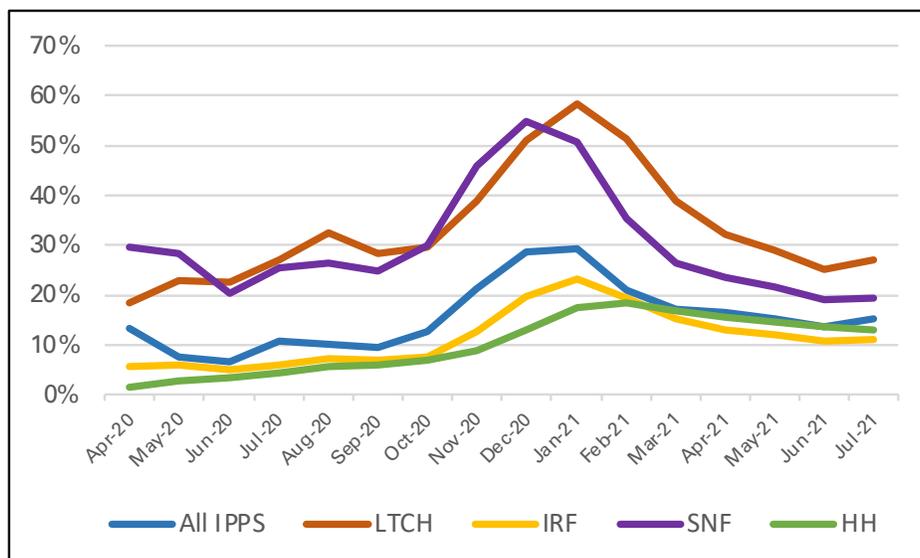
For more detail on these and related concerns, please see the [AHA’s August 2021 PAC PPS comment letter](#).

PAC Contributions to COVID-19 Response

Throughout the pandemic, all four PAC settings listed above have treated patients with active COVID-19, as well as patients recovering from the virus — albeit patients with different levels of acuity and medical needs. In addition, referring hospitals, to open more space for those requiring immediate care, continue to transfer patients to PAC facilities that correspond with their needed clinical competencies. In some areas, COVID-impacted patients are even bypassing a stay in a general acute-care hospital to streamline care protocols in response to pandemic pressures. In fact, at times there are even COVID-driven waitlists for certain PAC care.

The trends shown in the chart below illustrate how PAC has responded to the PHE in sync with that of referring inpatient PPS hospitals, shown in blue. Specifically, the chart shows each settings’ rate of concentration on treating COVID-19 patients, with LTCHs (shown in orange) and SNFs (shown in purple) exhibiting the highest concentration, relative to all cases.

COVID-19 Cases: April 2020 through July 2021 Percent of All Cases Within Setting: COVID Status On Current & Prior Claims



Source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, www2.ccwdata.org/web/guest/home.

COVID-19's Impact on PAC Service Delivery

The COVID-19 pandemic continues to significantly impact all health care providers, as shown below. **Most notably referring inpatient PPS and all PAC settings have experienced material decreases in case volume, which make it difficult to maintain the staff and resources needed to respond to the COVID-driven increases in average clinical complexity, as indicated by the chart's three indicators of case-mix index, average length of stay, and ICU days during the prior hospital stay. This trend of sicker patients being treated in PAC, especially as shown for the HH and LTCH settings, must be reflected in a unified PAC PPS.**

*Inpatient PPS Discharge Destination Data Rate of Change from Pre-PHE to PHE Period**

Inpatient Hospital Discharge Destination	Case Volume	Case-mix Index	Average Length of Stay	Average Number of ICU Days
All Inpatient PPS Discharges	-18.2%	6.9%	8.8%	12.6%
HH	-6.9%	5.0%	9.2%	10.1%
SNF	-30.8%	3.2%	8.8%	7.4%
IRF	-11.2%	3.6%	8.4%	6.9%
LTCH	-15.0%	8.5%	15.0%	15.2%

Source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, www2.ccwdata.org/web/guest/home.

*A comparison of the PHE period of Jan. 27, 2020 to Mar. 31, 2021 (approximately 14 months) versus the pre-PHE period of Nov. 23, 2018, 2019 to Jan. 26, 2020 (approximately 14 months).