September 14, 2021

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Project Director, Unified PAC PPS Prototype
RTI International

Kelsey Warren
Economist
RTI International

Re: Stakeholder Joint Response to RTI on the Unified Post-Acute Care Payment Prototype

Dear Dr. Silver and Ms. Warren:

The undersigned organizations are sending this response jointly to emphasize our shared concerns – both conceptual and technical in nature – related to RTI's current work to create a prototype for a unified post-acute care (UPAC) prospective payment system. We commend RTI's commitment to engaging in a collaborative process, and we appreciate RTI's consideration of our concerns as it contemplates its final report and the related report and recommendations that are required to be submitted by the Department of Health and Human Services (HHS) to Congress.

We recognize that RTI has a contract with the Centers for Medicare and Medicaid Services (CMS) with required deliverables and timelines mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). While the UPAC prototype development schedule is driven by legislation, the undersigned stakeholders recognize that this legislation is largely outdated at this point in time. **We therefore ask that the final RTI report clearly state, as RTI indicated at the meeting on June 3, 2021, that the UPAC payment system prototype under development is primarily a conceptual outline and is not in any way suitable for adoption for payment purposes**. Additionally, the report should state that the experts on the convened Technical Expert Panel consistently shared concerns with the prototype and its real-world application.

Adopting a payment system built upon this prototype will significantly impact patient care delivery and could create serious risks to patient safety, outcomes, and access to medically necessary PAC services. We have growing concerns that continuing down the pathway of blurring PAC clinical settings in an

attempt to best serve the specific needs of the patient by adopting a unified payment model will result in higher costs and diminished clinical outcomes for patients. We believe the time is ripe to reconsider how payment reform should be informed and pursued due to the systematic changes created by the effects of COVID-19 and the public health emergency (PHE), rather than attempting to account for the PHE through adjustments to non-representative administrative and other data. We would appreciate the opportunity to collaboratively engage with RTI and policymakers to explore more timely and consensus-backed reform options. At the very minimum, the prototype should be based on data collected after the PHE ends, consistent with the recommendation made by nearly every panelist during the June 2021 meeting.

As a supplement to these underlying structural points, we would like to highlight our shared comments and technical concerns related to the current development of the Unified PAC payment prototype. Many organizations participating in the Technical Expert Panel (TEP) held in June 2021, including our organizations, had significant difficulty answering the questions posed after the meeting due to an overall lack of sufficient, reliable, and validated data, as well as a number of missing elements and sufficient context to provide any meaningful commentary. Several of our primary concerns follow:

- Objective of the UPAC: The goal of the IMPACT Act was to standardize data elements collected across the settings of post-acute care that may be used to guide payment reform. RTI's work to date, however, focuses disproportionately on the cost of care across PAC settings, rather than on clinical factors and patient outcomes. That approach is also narrowly focused on a statistical study of factors that explain cost variance without considering the incentives being created that may impact patient care delivery, functional outcomes, access, health disparities and the viability of the PAC sector. We believe the PAC system that has developed over the past 40 years has distinct and defined settings of care that cater to the needs of a wide range of patients with highly variable needs. If cost savings are emphasized early on, this could distort the relative balance of the clinical provision of care between home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation hospitals and units (IRFs), and long-term acute care hospitals (LTCHs), each of which currently plays a distinct role in the PAC delivery continuum. Moreover, the ongoing and long-term fiscal impact of COVID-19 is highly uncertain across PAC settings and providers. This heightens our concern surrounding any prototype that looks to achieve cost-savings based on historical data that is not representative of current or future practice.

- Necessity of Representative Data: The 2017, 2018, 2019, 2020 and 2021 data are not appropriate to support the development of an operational UPAC as they reflect pre-, or partial, implementation of the new PAC payment systems (i.e., Patient-Driven Groupings Model (PDGM), the Patient-Driven Payment Model (PDPM), and LTCH site-neutral payment or reflect COVID-19-related delivery system changes that may or may not persist into the future. COVID-19 changed in fundamental ways how PAC providers operate, and it is unclear which practices will take root and which ones will revert to pre-COVID times. This means that only data collected in the future will be relevant for the design and implementation of any PAC payment reforms. Furthermore, as the PHE continues to upend the health care system and once again disproportionately impacts certain providers more than others, it is far from certain as to when this type of representative data collection could occur. [1] We provide below just a few

[1] For example, in the FY 2022 IRF PPS rule, CMS asserted that it expected to "see evidence of the PHE in the data for FY 2022 and beyond," and included similar language in the other PAC payment rules as well.

examples of the ways in which claims and assessment data have and continue to be skewed by the PHE:

- The intensity of therapy requirement and the 60 Percent Rule in IRFs have been waived, among numerous other substantive waivers and flexibilities implemented across each PAC setting such as SNF "three-day stay" requirement and the home health "homebound" requirement.
- Many PAC providers opted to abandon group therapy to reduce the risk of infection;
- Patients seek to go home earlier from institutional PAC settings mainly due to patient preference;
- Semi-private rooms became problematic due to infection control concerns;
- Staffing costs for nurses and other clinical staff have increased dramatically;
- New approaches have been developed to provide care safely;
- The types of patients seen in SNFs and HHAs have changed significantly with increased acuity and care needs;
- COVID-only buildings or units were established where treatment and results could vary relative to the general population;
- Use of technology and telehealth have increased dramatically; and
- The role of caregivers in home care has changed.

Given these concerns, RTI should note clearly that any unified PAC prototype based on data collected through (at least) 2022 could pose a serious risk to patient care. We ask RTI to explicitly note that a prototype built from this dataset should not be implemented, as all behavioral assumptions and data relationships would be suspect.

- Necessity of Accurate "Foundational" Data: There have long been suspected flaws in PAC data that serve to over or under pay PAC providers to treat patients with certain conditions, such as burns, AIDS, and End Stage Renal Disease (ESRD). Most alarming during the Technical Expert Panel discussion was the admission by RTI that the current PAC data does not differentiate the cost of treating patients with cognitive impairments, even though clinical consensus indicates these patients require more resources than patients without cognitive deficits. This same phenomenon can be seen with treatment of patients with limb loss and the apparent omission of cost data associated with prosthetic rehabilitation in PAC settings. To avoid "baking-in" to the PAC prototype these types of inequities in PAC treatment, we urge RTI to suggest how these issues could be addressed in the near-term as a necessary precursor to any new PAC payment model. PAC reform should work to improve on existing flaws. This is an opportunity to recognize cognitive status, comorbid mental health conditions, and social determinants of health of beneficiaries and accommodate those factors in the payment policies that address the mental health care and cognitive needs of beneficiaries during a PAC course of treatment.

- Pilot Testing/Demonstration/Phase-In: Given the complexity of the UPAC prototype and the vulnerability of the Medicare beneficiaries who will need PAC services in the future, the UPAC payment system must ensure that payment levels accurately reflect the resources necessary to effectively treat a wide variety of debilitating and serious conditions in the appropriate setting of care. A payment overhaul of this magnitude requires a comprehensive plan to monitor for and mitigate the risk of unintended consequences, particularly as they have an impact on patient access, quality, and health disparities. This plan should include pilot testing or demonstrations of

any PAC payment reform, conducted with PAC providers on a voluntary basis, to refine the payment system. Any subsequent expansion of a UPAC model and/or application of the model on a mandatory basis must only take place after extensive analysis of the pilot's impact on factors such as patient access and outcomes, and, of course, appropriate Congressional consideration and approval. We also recommend that RTI consider an evaluation as to how PDGM and PDPM have impacted PAC delivery (and the underlying data) in conjunction with or separate from this pilot testing, as we believe this type of analysis is imperative in the context of PAC reform.

These broader policy concerns are only part of the challenge in designing a UPAC payment system that meets patient and provider needs. RTI has a daunting task over the course of the next several months in answering myriad technical questions related to the construction of the UPAC payment prototype. RTI must decide on the relative balance between UPAC patient categorization components such as:

- **The Dependent Variable** – total cost which can include fixed operating costs and setting specific service costs
- **Unified Clinical Groups (UCGs)** – which at present represent 28 distinct clinical groupings
- **PAC Case Mix Groups (P-CMGs)** – which represent up to six subgroups per UCG and are based on functional assessment measures, categorized using a CAR-T regression model
- **Comorbid Conditions** – regressions on the dependent cost variable showing the relative costliness of various comorbid conditions (cost tiers) within UCG/P-CMG groupings
- **Out of model adjustments** - A series of additional "out of model" adjustments such as:
    - Transfers
    - Short stays
    - Decedents
    - Community entrants
    - Immediate prior PAC use
    - Outlier cases
    - Facility Specific adjustments (e.g., geographic, rural, low income)
    - And perhaps PAC setting specific adjustments
- **Development of payment weights -** These payment weights must be initially calculated and will likely change as the definition of total cost varies, new data become available, and the UPAC development process evolves. One key question is whether there are adequate case observations to support RTI's Three-Tiered Approach to Estimating Case Payment Weights for all UCG-P-CMG-comorbidity cost tier groupings.

Lastly, we note that the unanticipated delay in the prototype work (due largely and unavoidably to the COVID-19 PHE) has also resulted in key personnel transitions. Several associations have had to change their representative panelists on the TEP for a variety of reasons, raising concerns about continuity. Furthermore, RTI just recently announced the departure of one of the lead project analysts, adding a new complication to the pending work. We think these factors should be appropriately considered as policymakers weigh the merits of pausing prototype work at this stage and reinitiating analysis with data collected in a reasonable period following the PHE. This would not only solve a number of the analytical issues raised in this letter but would also allow a consistent group of panelists and analysts to engage on this important work.

For all these reasons, we continue to collectively advocate for a commonsense "reset" of the IMPACT Act timeline through enactment of The Resetting of the IMPACT Act (H.R. 2455). We provide these comments for your consideration, however, under the assumption that the current implementation timeline is preserved. In that event, we encourage RTI to recognize in its final report that the prototype is merely a conceptual design with limitations and requires further study with updated data to be collected and reviewed after the PHE. We also urge RTI to highlight areas where it found insufficient data to accurately construct the UPAC prototype. Only through candid reporting on the gaps in the data and areas of concern will the development of a future PAC payment system be accurately informed and ultimately ready to meet the needs of Medicare beneficiaries.

Thank you and please let us know if you have any questions.

Sincerely,

American Academy of Physical Medicine and Rehabilitation (AAPM&R)
American Health Care Association (AHCA)
American Medical Rehabilitation Providers Association (AMRPA)
Coalition to Preserve Rehabilitation (CPR) Steering Committee*
Federation of American Hospitals (FAH)
LeadingAge + VNAA
National Association of Long Term Hospitals (NALTH)
National Association for Home Care & Hospice (NAHC)
Partnership for Quality Home Healthcare

* CPR Steering Committee members: Brain Injury Association of America, Center for Medicare Advocacy, Christopher & Dana Reeve Foundation, Falling Forward Foundation, National Multiple Sclerosis Society, and United Spinal Association