Charles N. Kahn III
President & CEO

Statement for the Record on Behalf of the Federation of American Hospitals
Committee on Ways and Means Subcommittee on Health
"Examining the COVID-19 Nursing Home Crisis" Hearing
June 25, 2020

The Federation of American Hospitals appreciates the opportunity to submit a statement for the record on the House Ways and Means Committee Subcommittee on Health hearing titled "Examining the COVID-19 Nursing Home Crisis" held on June 25, 2020. The Federation of American Hospitals is the national representative for over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

Introduction

The COVID-19 pandemic has raised numerous issues and questions around the operational and clinical capabilities of America's post-acute care (PAC) providers (inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), and home health agencies (HHAs)), including patient outcomes and safety. A significant aspect of the 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act was the mandate to design a Unified Post-Acute Care (PAC) Prospective Payment System (PPS). The law laid out a timeline for the collection and reporting of substantial amounts of quality and patient data, followed by an eventual report from CMS to Congress on a technical PAC PPS prototype.

This timeline, however, must now be revisited and updated in order to reflect the reality that IMPACT Act data from 2017-2019 is no longer an accurate depiction of the post-acute care landscape. In the six years since the enactment of the IMPACT Act, significant changes in each of the four PAC setting payment systems have occurred, including CMS's concerted shift towards patient-driven reimbursement, and now the unprecedented impacts of the COVID-19 pandemic. Together, these dynamics have created important shifts in the way post-acute care is

delivered and paid for, shifts that are not sufficiently captured in the data CMS is currently relying on from 2017-2019 to inform its development work on the PAC PPS technical model. Given these changes, the Federation of American Hospitals (FAH) urges an immediate refresh of the Unified PAC PPS mandate outlined in the IMPACT Act as part of the next COVID-19 relief package.

Each PAC Setting is Unique and Has Been Uniquely Affected by COVID-19

The COVID-19 experience has revealed that there are many ways in which PAC settings fundamentally differ from each other, not only in the services provided and governing regulations, but also in the ways they have each responded to support the treatment and recovery of individuals impacted by the virus. LTCHs are treating the most severe cases needing ventilators, LTCHs and IRFs are supporting patients' rehabilitation and recovery, hospital-based SNFs are scaffolding the needs of their host hospitals, freestanding SNFs are adapting to address infection control and other challenges, and HHAs have expanded their use of telehealth to limit contact while maintaining the provision of care to qualifying patients in their homes.[1]

Each PAC setting is contributing to the COVID-19 fight in its own unique fashion. HHAs, for example, have very low overhead costs, enabling them in a variety of ways to support patients at home who need low intensity care. Patients in IRFs and LTCHs benefit from the Medicare requirements for frequent physician-level clinical supervision. At the same time, freestanding SNFs do not have as substantial clinical licensure requirements as other institutional PAC settings and thus have stretched capabilities to make up for shortfalls in local supply of IRFs and LTCHs. In addition, there is significant variation in how PAC providers operate market by market – depending on the mix of patients and the provider types available in the local area.

The COVID-19 Crisis is Multifaceted and Far from Over

The provision of post-acute care has drastically changed during the COVID-19 pandemic. As the ongoing national emergency shows no signs of abatement, these adaptive changes may become permanent or may signal a further evolution to meet the rapidly changing service needs of patients. The corresponding economic crisis and massive reduction in elective surgeries (a precursor for much PAC utilization) in many areas has further unsettled the PAC landscape. Unfortunately, these disruptions are far from over, as many Southern and Western states are now experiencing their first wave of significant outbreaks.

PAC providers, like the rest of the health care provider community, are not currently operating under "normal" conditions nor will they for the foreseeable future. The COVID-19 pandemic will impart lasting changes on the entire health care delivery system. However, these structural and financial changes are unpredictable from today's vantage point. Questions without readily available answers are emerging because of COVID-19, and health care providers and the government are continually learning and adapting their responses. For example, notwithstanding the important regulatory flexibilities enacted by Congress and those advanced by the Department

[1] American Hospital Association, Fact Sheet: Reset IMPACT Act to Account for COVID-19 Lessons on Post-acute Care, June 2020, https://www.aha.org/fact-sheets/2020-06-24-fact-sheet-reset-impact-act-account-covid-19-lessons-post-acute-care.

of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) through regulation and under its waiver authority, it is unclear the extent to which current pandemic Medicare PAC PPS policies will ultimately impact PAC PPS policies and the provision of care in the future. Policymakers must therefore adopt a cautious approach to post-pandemic Medicare PAC payment policies based only on comprehensive data and information that is readily available post pandemic. As payment systems tend to reinforce the existing case-mix groups, PAC claims and assessment data considered both before and during this national emergency are not valid or appropriate to use in subsequent rate setting or modelling efforts because they do not yet represent a "new normal state" of care.

Accurate and Representative Data are Vital

The design of a unified payment system that spans multiple care settings is no small undertaking, even in the absence of far-ranging exogenous shocks to the health care system like COVID-19. All PAC settings are currently in the midst of adapting to setting-specific overhauls (the Patient Driven Groupings Model in HHAs, the Patient Driven Payment Model in SNFs, a fundamentally changed case-mix system in IRFs, and the adjustment to fully site-neutral payments for non-qualifying cases for LTCHs), while a pandemic continues to radically change the ways in which patients interact with the health care system and the evolving technology available to providers, such as telehealth. With these additional challenges, building an accurate PAC PPS to produce desirable expected outcomes becomes all but impossible due to forces that complicate the collection, completeness, and representativeness of underlying claims and assessment data.

Furthermore, there remains a lack of robust, standardized patient data across all settings from which to base the model's development. CMS recently announced its delay in the release of new or revised Standardized Patient Assessment Data Elements (SPADEs) in all four PAC settings [2,3,4] to allow providers maximum flexibility in responding to the COVID-19 public health emergency. While this decision alleviates burden on providers in the short term, it hinders efforts to build a Unified PAC PPS which requires standardized, established data inputs across settings. As part of the revised timeline for IMPACT Act implementation, it is crucial that CMS build in time for a public release of any and all data that could inform the model's development to allow for independent analysis that can then inform future work.

---

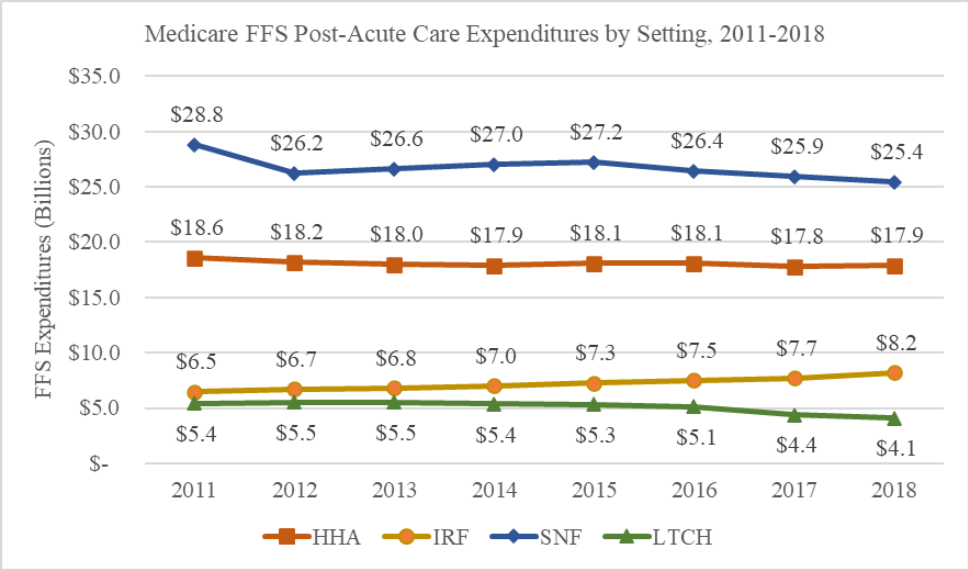
[2] CMS, Delayed: Release of Updated Versions of IRF and LTCH Assessment Instruments (and Supporting Training), May 2020, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.

[3] CMS, Delayed: Release of Updated Version of the Home Health Assessment Instrument (and Supporting Training), May 2020, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.

[4] CMS, Delayed: Release of Updated Versions of SNF Assessment Instrument (and Supporting Training), May 2020, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.

The FAH notes that PAC costs have remained broadly stable since 2012 and, in some cases, have decreased (as shown in Exhibit 1). Overall, PAC volume from 2011-2018 fell by 8.8% and overall payments fell by 6.2%. These reductions suggest that if a Unified PAC PPS implementation is delayed until after the pandemic subsides, and data on this post-COVID-19 state can be collected and understood, costs will not run rampant in the meantime. Careful and thorough data collection, analysis, and modeling is needed to support an accurate and effective Unified PAC PPS.

Exhibit 1: Medicare FFS Post-Acute Care Expenditures by Setting, 2011-2018



Source: Dobson | DaVanzo Analysis of MedPAC Reports to Congress, 2011-2018

Moving Forward

Now is not the time to risk patient care and rush ahead with the design of a Unified PAC PPS that relies on pre-COVID-19, pre-PAC setting PPS overhaul data. Instead, it would be prudent to wait until the health care system stabilizes following the end of the pandemic, then gather data that reflects the adjustments made to address COVID-19. These adjustments are likely to be very different from one PAC setting to another, meaning that as of now there is no clear understanding as to how PAC settings will differentiate from one another in the future, how patient "overlap" between the settings might evolve, and which new diagnostic and treatment technologies will move forward more permanently.

Ultimately, a comprehensive understanding of the evolving differences across PAC settings will be necessary so that, in the course of modelling a unified PAC PPS, decisions on which aspects should be preserved and which should not can be made on an informed basis. A Unified PAC PPS put in place prematurely could well produce significant unintended consequences with unknowable opportunity costs and patient consequences. We should take a fresh look at what the normalized data are telling us as we move through and beyond the COVID-19 pandemic response and become more familiar with the new payment systems.

A thoughtfully designed, Unified PAC PPS founded on accurate, reliable data from each PAC setting is important for the sustainability of our health care system and the assurance that seniors will get the right care, at the right time, in the right post-acute setting. That is why the FAH strongly supports a careful reset of the IMPACT Act's PAC PPS timeline in the next COVID-19 relief package – to expand the mandated Unified PAC PPS timeframe and to allow for consideration of how PAC will adjust to the new PAC PPS systems and COVID-19 pandemic.

****

Thank you again for the opportunity to comment. If you have any questions regarding our comments or need more information, please contact Erin Richardson at erichardson@fah.org or 202-624-1500.