

February 6, 2015

Marilyn B. Tavenner
Administrator
Attention: CMS-1461-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244-1850

**Re: Medicare Program: Medicare Shared Savings Program;
Accountable Care Organizations; 79 Fed. Reg. 235 (December 1, 2014);
CMS-1461-P**

Dear Administrator Tavenner,

On behalf of our more than 12,000 skilled nursing, assisted living, and other post-acute care provider organizations, the American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rules and the suggested waivers to the Medicare Shared Savings Program.

We appreciate the high level of attention CMS continues to give to these very important issues, and we stand ready to assist the agency in any way possible in achieving its goals of advancing new models of payment and care delivery that seek to improve patient outcomes and reduce costs. We also appreciate the agency's recognition that skilled nursing providers are a critical component in the effective and efficient delivery of care across the continuum, as well as the need to bring providers to the table as alternative payment model policy evolves.

While we support some of the concepts put forth in this proposed rule, we also have very strong concerns about others, which we have outlined in detail, below. AHCA is dedicated to advancing the Department's goals for transitioning fee-for-service payments to alternative payment models, so long as it's done in a manner that will allow skilled nursing providers, as well as the millions of patients for whom they care every year, to thrive.

Sincerely,

/s/

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AHCA Response to Proposed ACO Rules and Waivers

The Medicare Shared Savings Program (MSSP), established by Section 1899 of the Social Security Act (SSA) and created as part of the Affordable Care Act, seeks to promote accountability for a patient population, encourage coordination of items and services, and foster care delivery methods that focus on quality and efficiency through the development of Accountable Care Organizations (ACOs). Final regulations establishing the MSSP were published on November 4, 2011. After more than two full years of operational experience, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule to revise the MSSP on December 1, 2014 together with commentary. The purpose of the proposed rule, as stated by CMS, is to incorporate guidance issued by CMS since the MSSP was first established, as well as to propose regulatory additions and revisions to the program. The commentary also requested feedback on proposals under consideration by CMS to exercise its waiver authority to advance program goals. The proposed rule was published in the Federal Register on December 8, 2014, giving parties 60 days from publication to offer comments on the proposed rule.

I. PROPOSED RULES

a. New Contracting Requirements

CMS has proposed clarifying requirements for Participation Agreements and ACO Participation Agreements. AHCA membership supports these regulations for the reasons set forth in CMS' Commentary. Many of AHCA's members have been confronted by copies of Participation Agreements that inadequately document the arrangement as described by CMS in the Commentary. Consequently, the agreements may lack basic information about the ACO, such as the true identity of the parties, because they are not accurately identified in the Participation Agreement. AHCA also supports the requirements for ACO Participation Agreements. The proposed rules will contribute to transparency of the ACO arrangements.

This transparency is particularly important to the Skilled Nursing Facility (SNF) members represented by AHCA. Although SNFs qualify to serve as "participants" in ACOs, they typically do not contract with ACOs as "participants," as defined in the existing regulations, and are also not usually a "provider/supplier" who bills through a participant. Frequently, SNFs are either asked to sign on as members of a loosely organized preferred provider network or are asked to sign a contract that may or may not be intended to establish an "other entity" relationship as defined in existing regulations and CMS guidance.

In recent months our members have raised significant concerns and challenges around the process of contracting with ACOs. In their experiences to date, it is typical that an ACO agreement will include onerous requirements (e.g., extensive data collection and reporting, adherence to certain clinical processes and other policies) without the ACO making those prescribed policies available for the SNF to review ahead of time. So in

effect, SNFs are typically being asked to sign (or not sign) an agreement without fully understanding exactly what will be required of them. Therefore, AHCA strongly supports the proposed regulations that are intended to ensure that the contracting process is strengthened and made more transparent. Although CMS does not include new requirements for other individuals or entities performing services for the ACO, the requirement to make such agreements available to CMS upon request should hopefully enhance the quality of these agreements.

b. Composition and Fiduciary Duties of Governing Board

CMS has proposed certain rules that are designed to strengthen governance of the ACO. The proposed rule clarifies that the ACO governing body must be different than the governing body of a specific ACO participant. The rule goes on to state that the governing body must be concerned primarily with the governance of the ACO and not the interests of a dominant participant. AHCA supports these changes because it believes that these will encourage greater responsibility for achieving the mission of the ACO and reduce the likelihood that an ACO will be operated to favor a powerful participant. The provisions should encourage accountability on the part of the governing body to review the totality of care provided by the various actors contributing to the performance of an ACO, whether they are participants, providers/suppliers or other entities. Dominance on the governing board by one powerful participant can result in decision-making that is detrimental to the mission and operation of the ACO.

To further strengthen the role of the governing body, AHCA strongly urges CMS to consider requiring that “other entities” be represented on the governing body as well. As explained earlier in, post-acute care providers are much more likely to be “other entities” and not recipients. These providers play a key role in the care of patients at a critical point along the continuum and yet, they do not have input into governance, and further, often have no input in management/clinical decisions that may directly affect how they care for patients. Curative and acute care services and related delivery are fundamentally different from rehabilitative services. In order for an ACO to effectively coordinate a full portfolio of services which includes PAC, the Association believes PAC expertise and the perspective of those providers is essential on an ACO governing body. With respect to this last point, as we explain in the following section, AHCA strongly supports new emphasis on coordination of patient care with PAC providers and believe a requirement for governance representation would strengthen the care coordination proposal as well.

c. Required Processes to Coordinate Care

CMS has proposed several new specific requirements to encourage ACOs to focus on providing and improving technologies to improve coordination of patient care. Specifically, CMS has included a proposed rule to require ACOs to encourage health information sharing across the continuum of care, including advancement of telehealth services. The same section of the rules includes a new requirement for ACOs to partner with long-term and post-acute care providers to improve care coordination for the ACO assigned beneficiaries.

AHCA supports these measures because we believe such information exchange will improve patient care and assist providers in monitoring care. AHCA also specifically supports the expansion of telehealth services for reasons set forth in the section on Telemedicine later in this letter. An expanded use of telehealth services in SNFs will ensure that patients receive the care that they need without unnecessarily transferring them to physician offices, clinics or hospitals. Finally, AHCA strongly supports the focus on partnering with PAC providers in appropriate clinical patient care management as required by the proposed rules. Without this requirement, AHCA believes that ACOs will be increasingly likely to shift patients to lower-cost settings, in order to save on total cost of care, even if not in the best clinical interest of the patient. AHCA's members already are seeing a great deal of such behavior in markets with relatively high ACO penetration. Additionally, without a requirement for meaningful transition coordination, untimely hospital readmissions are likely to increase.

There is strong evidence emerging which demonstrates coordination of care between acute and PAC providers enhances the care of the patient and will contribute to the effective use of these resources. Early case studies suggest that care coordination between acute and PAC providers yield positive results. In one example, Hospital Corporation of America (HCA) targeted readmissions of cardiac heart failure (CHF) patients by applying a care management approach in underperforming HCA rural hospitals. This effort resulted in a decrease of 32.5% readmissions for CHF patients.¹ As another example, a study conducted at Vanderbilt revealed markedly reduced early readmissions to the hospital when the handover of care between the hospital and SNF is better managed.²

d. Extension of Track 1, Changes to Track 2, and Addition of Track 3

CMS expressed concern in the proposed rule that the current transition from one-sided risk to two-sided risk is too steep. Currently, a Track 1 ACO must transition to Track 2 after its first three-year agreement period. This may result in smaller and less experienced ACOs, who would not be in a position to take on Track 2 risk, dropping out of the MSSP altogether. Thus, CMS proposes an option of participating in Track 1 for a second agreement period, provided the ACO meets certain quality and financial criteria. Further, Track 1 ACOs would have a reduced maximum sharing rate, from 50 percent down to 40 percent. CMS also proposed a modification to Track 2 ACOs, allowing the minimum savings rate and minimum loss rate to vary based on the ACOs number of assigned beneficiaries.

Furthermore, CMS proposes the creation of a new risk-based Track 3 that includes certain features to make the performance-based risk models more attractive to ACOs. These features include prospective assignment of beneficiaries at the start of the

¹ The Advisory Board Company, "Partnering with Post Acute Providers Leads to Lower Readmissions, Better Care Coordination." Available at: <http://www.advisory.com/~media/Advisory-com/Technology/Crimson-Care-Management/HCA-Case-Study-V2-121214.pdf>.

² Govern, P., "Program aims to reduce Medicare readmission rates." Vanderbilt University Reporter, available at: <http://news.vanderbilt.edu/2014/02/program-aims-to-reduce-medicare-readmission-rates>.

performance period and a limited reconciliation in which only ineligible beneficiaries would be removed at the end of the year and no new beneficiaries would be added. We believe that these proposed changes should enable ACOs to remain in the program and would provide a smoother transition for ACOs as they accept more performance-based risk. However, we recommend CMS develop formalized guidance to ACOs outlining the types of behaviors that are and are not allowed with regard to a prospectively assigned patient population. We feel that prospective alignment of beneficiaries may tempt ACOs to treat these populations as if they are enrolled managed care populations and apply more aggressive care management strategies that limit patient choice.

AHCA also urges CMS to further expand the Shared Savings and Losses section by formalizing agency guidance regarding shared saving with “other entities.” In keeping with CMS’ stated purpose of this proposed rule to formalize prior agency guidance, we ask CMS to review the guidance on “other entities” currently posted at its website. The guidance notes “other entities” may qualify for shared saving because “[t]he ACO decides how to use or share savings resulting from an ACOs participation in the Medicare Shared Savings Program.” We strongly urge CMS to formalize this principle, allowing entities that are not ACO participants, providers, or suppliers to share in an ACOs savings if it advances the ACOs goals of increased care coordination, improved quality, and more efficient care delivery. Formalizing the guidance may ease ACOs’ reservations about entering into shared savings contracts with “other entities,” thereby extending their accountability and alleviating some quality and cost concerns.

e. Changes to Beneficiary Alignment

As noted above, one proposed change is to allow prospective assignment of beneficiaries at the start of the performance period for Track 3 ACOs, rather than using Track 2’s preliminary prospective alignment with retrospective reconciliation. The purpose of this change is to offer greater certainty and a more narrowly defined target population for the ACOs. CMS requests comments, given its concern that this may encourage ACOs to focus too narrowly on this subset of beneficiaries.

While we encourage proposals that enhance integration of beneficiary care of , AHCA believes CMS should emphasize more strongly the importance of beneficiary freedom to choose providers. We recognize there are appropriate methods for encouraging certain choices by beneficiaries, but many ACOs have implemented more aggressive and somewhat questionable practices to require patient referrals stay within ACOs. We believe such questionable behavior is more pervasive than CMS might realize, and we strongly recommend that CMS more actively police these practices or impose other requirements to insure that beneficiaries understand their right to choice in these circumstances.

II. PROPOSALS FOR WAIVER OF PROGRAM REQUIREMENTS

In the proposed rule, CMS notes that ACOs are reluctant to accept two-sided performance-based risk arrangements, with the result that 98 percent of MSSP ACOs have elected to participate in shared savings under Track 1, only. In an effort to encourage participation in two-sided performance-based risk models, CMS proposes, among many other revisions, several options for increased flexibility using CMS' waiver authority. Under Section 1899(f) of the SSA, CMS may waive certain Medicare program rules as necessary to carry out the provisions of the MSSP. The proposed waivers of interest to AHCA membership involve the SNF 3-day rule, billing and payment for telehealth services, and discharge planning to post-acute care settings, which are discussed in detail below. AHCA strongly supports the use of the waiver authority to remediate the negative effects of these requirements for the reasons set forth in the following sections.

a. SNF-Three Day Rule

Congress included SNF coverage in the initial Medicare legislation in 1965 as a less expensive alternative to the final, convalescent portion of a beneficiary's inpatient hospital stay. In order to target SNF benefits to a limited population of beneficiaries who require a short-term, intensive SNF stay, Congress included a 3-day stay requirement at Section 1861(i) of the SSA. The 3-day rule mandates that beneficiaries have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for coverage of inpatient SNF care.

In the proposed rule, CMS acknowledges it might be medically appropriate for some patients to receive SNF care or rehabilitation services without a prior hospitalization or with an inpatient hospital stay of less than 3 days. Waiver of the 3-day rule may improve quality of care for patients for whom SNF care is clinically appropriate while also producing cost savings for hospitals. The provision could contribute to ACOs' continued participation in the MSSP. We agree with the principle and therefore, urge that the waiver be broadly applied to ACOs.

As CMS notes in its Commentary, the waiver would permit ACOs to manage care more efficiently and provide more clinically appropriate services. In view of its potential impact on cost and quality, as a general principle, we believe the waiver should be broadly applied rather than to only a handful of ACOs. CMS experience with use of the waiver provides sufficient grounds for broader application.

Specifically, we disagree with CMS' position that Track 3 ACOs are better candidates for two reasons:

1. CMS focuses on the increased risk of Track 3 ACOs, but AHCA does not believe there are compelling differences in incentives between the three tracks. Track 2 ACOs also take on considerable risk by being held accountable for 60 percent of any losses. Additionally, Track 1 ACOs have

substantial financial consequences in terms of potential savings. Thus, we believe all ACOs have a considerable stake in employing the waiver of the 3-day rule judiciously.

2. CMS also argues that the prospective assignment approach of Track 3 will improve CMS' ability to monitor the use of the waiver. Monitoring prospectively assigned beneficiaries under Track 3, however, will not differ significantly from monitoring preliminarily prospectively assigned beneficiaries under Tracks 1 and 2. As noted by CMS, the assignment methodology will remain the same for all three tracks. This means that all ACOs will have a defined patient population covered by the waiver of the 3-day rule. The difference lies only in the degree of reconciliation at the end of the performance year, with some ACOs simply adjusting for beneficiaries who no longer meet eligibility criteria and others undergoing retrospective reconciliation that may add new beneficiaries. Such differences, however, will not impact the monitoring of the initial patient pool, because CMS can gather data on all prospectively assigned and preliminary prospectively assigned beneficiaries as it pertains to their costs and success under the three-day rule waiver.

AHCA also disagrees with CMS' proposal to limit patient SNF eligibility to those who do not reside in nursing homes for long-term care at the time of the decision to admit to a SNF. If the goal of the waiver is to encourage medically appropriate care for all patients, regardless of other factors, hard limits on patient eligibility such as this will detract from providers' ability to exercise their best clinical judgment regarding whether SNF care is medically appropriate for a given patient.

CMS indicates it would require the same criteria for eligibility as used for the 3-day rule waiver under the Pioneer ACO model which went into effect as of April 7, 2014. While AHCA appreciates CMS' continued waiver testing in the Pioneer ACO program, we do not agree with the process the agency has put in place in order for SNF waiver to qualification. First, AHCA does not believe CMS pre-approval process for SNFs or ACOs is needed. To promote efficiency in implementing the waiver, ACOs and SNFs should have to comply with all guidelines set by CMS, such as the documentation requirements, but should not need to wait for CMS approval unless they are actually cited for not following the requirements. Second, we believe it is inappropriate to use CMS's Five-Star rating system to determine eligibility for a waiver unless Five-Star is revised to have a stronger focus on short stay quality measures; currently only 3 of the 11 Quality Measures are short-stay quality measures. While we agree with CMS that quality measures should be evaluated in determining which SNFs should be eligible to participate, we believe more appropriate measures are available or could be developed with support from stakeholders such as AHCA.

CMS seeks comments about the sufficiency of other quality performance measurements, such as the new Skilled Nursing Facility 30-Day All-Cause Readmission measure and other quality measures. AHCA strongly believes that any quality measures used in

determining SNF waiver participation be risk-adjusted to account for the variation in medical complexity of patient populations between SNFs. Since there is a strong desire among SNF providers to participate in such a waiver, using a readmission measure that is not risk-adjusted could create strong incentives to avoid higher-acuity patients who are sicker and therefore more likely, as a function of their clinical condition, to be readmitted to the hospital. We ask that CMS consider instead using AHCA's PointRight Pro 30 © (NQF #2375) hospital readmission measure, which is risk-adjusted to more adequately account for a patient's clinical condition.

We also recommend that CMS collaborate with industry stakeholders in the design and implementation of any new quality measures that will be used in evaluating SNFs for the purposes of qualifying for a waiver of the 3-day rule. AHCA has extensive experience in designing, researching and testing various quality measures, and we stand ready to continue working with CMS to determine the measures that are the most effective and appropriate to use.

CMS also seeks input about whether SNFs should be required to be ACO participants or ACO providers/suppliers in order to qualify for the waiver. Per our previous comments, since the vast majority of SNFs contracting with ACOs are doing so under an "other entity" arrangement, AHCA does not believe that SNFs should be required to be ACO participants or ACO provider/suppliers.

b. Telemedicine

Congress specifically referenced the use of telehealth as a process through which ACOs could promote evidence-based medicine and coordinate care. As defined in Section 1834(m)(4)(F)(i) of the SSA, Medicare telehealth services include professional consultations, office visits, office psychiatry services, and any additional service specified by the Secretary when furnished via a telecommunications system.

Generally, Medicare reimbursement for telehealth services requires, in addition to several other conditions, the individual receiving the services to be in an eligible originating site. An "originating site" must meet two types of criteria: geographic and site type. The geographic criteria require an originating site be located in either a rural Health Professional Shortage Area, a county that is not in a Metropolitan Statistical Area, or at an entity that participates in a Federal telemedicine demonstration project. For the site type criteria, eight sites qualify as originating sites, including physician offices, critical access hospitals, rural health clinics, SNFs, and Federally Qualified Health Centers.

A waiver of the telehealth requirements proposed by CMS would waive both sets of criteria that define an "originating site." Given many ACO providers are located in urban or suburban areas, the waiver would allow a broader range of ACOs to use telehealth and other enabling technologies. According to CMS data analyzed by the Center for Telehealth and eHealth Law, CMS spent less than \$5 million in 2011 on telehealth services, out of a total budget of \$500 billion. CMS welcomes "information from ACOs and other stakeholders about the use of such technologies to coordinate care for assigned

beneficiaries.” A recent survey of 62 ACOs focusing on health IT adoption found most, if not all, ACOs face significant, widespread barriers to adopting telehealth technologies.³ CMS should encourage much wider adoption of telehealth technologies among all provider communities, but especially among ACOs.

For the two reasons mentioned above, AHCA disagrees with CMS that Track 3 ACOs are the best candidates for the originating site waiver. Additionally, CMS seeks to increase the number of ACOs participating in two-sided performance-based risk tracks. The potential for improved care coordination and reduced costs from increasing the use of telehealth services may encourage Track 1 ACOs to take on risk in Track 2 or Track 3.

AHCA agrees with CMS’ proposal for the scope of the waiver to include both the geographic and originating site type requirements to qualify as an eligible originating site. This will enable PAC facilities in any location to be considered originating sites.

In response to CMS’ question regarding how telehealth should be defined and what services it should include, AHCA believes CMS should expand the telehealth definition under the waiver to include more services than currently covered by Medicare. Such changes would mean covering more telehealth modalities, including store-and-forward transmission and remote patient monitoring, as well as services such as remote visits and e-consults. These additional modalities can have significant impacts on clinical care: store-and-forward technology helps patients access specialty care when there are few such providers in their locality and remote monitoring increases accountability, often resulting in reduced readmission rates. Using this broader definition would provide useful data to Medicare when assessing future requests for additional services to be covered under the Medicare Physician Fee Schedule. Additionally, these technologies will help ACOs meet CMS’ stated goals of improving care coordination, patient accountability, quality and efficiency.

In order to expand providers’ use of telehealth services, AHCA also strongly encourages offering reimbursement for investment in telehealth enabling technologies. CMS could require providers to meet thresholds for use and performance to qualify for investment-based reimbursement. These standards could imitate the meaningful use requirements for certified EHR technology under the Medicare and Medicaid EHR Incentive Programs.

Measures for meaningful use and quality might be derived from assessment and outcomes measures developed by national organizations such as the American Telemedicine Association (ATA). The ATA brought together experts in the field to develop comprehensive practice guidelines for telemedicine that include quality assessment measures. In addition, the organization developed, through an expert consensus approach, a Lexicon of Assessment and Outcome Measures. While AHCA does not endorse any specific clinical guidelines, we are aware of the robust resources

³ iHealth Beat, “Survey: ACOs Struggle to Adopt Advanced Health IT Functions.” Available at: <http://www.ihealthbeat.org/articles/2014/9/25/survey-acos-struggle-to-adopt-advanced-health-it-functions>.

developed by organizations that have studied the delivery and assessment of telehealth services.

c. Discharge Planning

As a Medicare condition of participation (CoP), hospitals must have a discharge planning process in place for all patients pursuant to 42 C.F.R. 482.43. The process includes several steps: determining the appropriate post-hospital discharge destination for a patient, identifying what the patient requires for a safe transition from the hospital to the discharge destination, and beginning the process of meeting the patient's identified post-discharge needs.

Hospitals also must actively involve patients or their representatives throughout the discharge planning process. As part of the discharge plan, the hospital must, when applicable to the patient's post-discharge needs, provide a list of home health agencies (HHAs) or SNFs that are available to the patient, participate in the Medicare program, and serve the geographic area in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. Further, the hospital must inform patients or their representatives of their freedom to choose among the providers and must respect their preferences when they are expressed. The hospital may not direct patients to specific providers or otherwise limit their choices. Any HHA or SNF with which the hospital has a disclosable financial interest must be indicated on the list.

Upon analyzing claims data, some ACOs have recognized certain PAC providers may deliver higher-quality and lower-cost care than others. As a result, they suggested a waiver to allow them to recommend high-quality SNF and HHA providers with whom they have a relationship. CMS is therefore proposing a "very narrow waiver" of the prohibition that the hospital may "not specify or otherwise limit the qualified provider which may provide the post-hospital home services" as found in Section 1861(ee)(2)(H) of the SSA and the subsequent CoP regulations. The waiver would not impact the requirements to notify the patient of their freedom to choose and to respect the patient's or family's preferences when possible. The hospital would still need to present a complete list and not limit the providers, but could recommend specific providers on the list with whom they have a financial and/or clinical relationship.

CMS also anticipates certain limitations on recommended providers. For instance, the waiver would not cover post-acute providers who pay to be included by the ACO participant or ACO provider/supplier. Additionally, CMS anticipates requiring quality criteria for recommended providers, such as a rating of 3 or more stars for SNFs under the CMS 5-Star Quality Rating System. Documentation of the notifications would also be necessary, and would need to include evidence the patient or patient's family was informed of the provider's quality of care, any existing relationship between the hospital and provider, and any other reason why the provider was recommended.

AHCA has very strong concerns about CMS' proposed rules regarding a waiver, however "very narrow" it may be, of existing discharge planning regulations that safeguard

Medicare beneficiaries' freedom of provider choice. As stated earlier, we believe that ACOs are already engaging in questionable behaviors around patient steering to certain preferred PAC providers. Decisions appear to be made that are financially driven and not necessarily in the best clinical interest of the patient. We are concerned that if CMS gives any leeway to ACO providers here, however little, it will exacerbate these behaviors. Expansion of such behavior will have negative implications for beneficiaries and further strain ACO-SNF relationships in many markets

While AHCA believes that an ACO should make recommendations on the basis of the quality of the PAC provider, we strongly urge CMS lead in development of standards rather than relying on each ACO to develop its own idiosyncratic standards. These standards should reflect quality of care and the degree of integration of clinical services. In the absence of standards based on consensus among CMS and PAC profession experts, ACOs are strongly incentivized to encourage beneficiaries to choose merely the lowest cost PAC provider, opting to risk the chance of a hospital readmission in return for the potential financial benefit of significantly reducing spending.

While AHCA would support the development and use of care coordination and accountability measures between the SNF and ACO providers, and we stand ready to assist CMS in defining these standards, we strongly recommend any standards used to apply the waiver extend to all qualified post-hospital providers and not just ACO participants or providers/suppliers. As noted earlier, most PAC providers are not contracting with ACOs as participants or provider/suppliers, but rather as "other entities." The requirement that a PAC provider be an ACO participant or provider/supplier to be recommended by a discharge planner would severely limit the benefit of the waiver to a very narrow subset of providers.

We appreciate the opportunity to comment on these very important proposed rules, and we stand ready to assist CMS in any way that can be helpful in further development of rules and standards. Please do not hesitate to contact **James Michel** at (202)898-2809 or jmichel@ahca.org with any questions or feedback you may have.