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Advancing Health in America

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Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Crosson:

The Medicare Payment Advisory Commission (MedPAC, or the Commission) will vote this month on payment recommendations for 2020. 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) asks that commissioners consider the following issues that would have a significant impact on hospitals, health systems, other providers and Medicare beneficiaries before making final recommendations.

Regarding the discussions during the December meeting and the Commission's draft recommendations, we:

- **Support MedPAC's recommendation to provide current law market-basket updates for the hospital inpatient and outpatient prospective payment systems (PPSs).**
- **Support the concept of appropriately linking quality performance to payment, but have significant concerns about the design of the Hospital Value Incentive Program (HVIP).**
- **Urge the Commission to vote in favor of the current law market-basket update for the long-term care hospital (LTCH) PPS.**
- **Urge MedPAC to support the current law market-basket update to the inpatient rehabilitation facility (IRF) PPS.**
- **Urge the Commission to provide the current law market-basket update for hospital-based skilled nursing facilities (SNFs).**

Our detailed comments on these issues follow.

HOSPITAL INPATIENT AND OUTPATIENT UPDATE RECOMMENDATION

The AHA agrees with MedPAC that current law updates for both the hospital inpatient and outpatient PPSs are necessary in 2020. We appreciate the Commission's recognition that Medicare payments will fall even further below the cost of providing care. Specifically, in 2017, the average hospital had an overall Medicare margin of *negative 9.9 percent,* further demonstrating a concerning downward trend of Medicare margins during the past five years. MedPAC has projected that the overall Medicare margin will continue to decline to *negative 11 percent* for 2019, the lowest margin in Medicare's history. Indeed, according to the MedPAC chart book, Medicare has not fully covered the costs of caring for Medicare beneficiaries since 2002. Moreover, for the second consecutive year, MedPAC found that overall Medicare margins of "efficient" hospitals were negative – and decreased since 2016 – indicating that Medicare payments fail to cover costs even for the majority of "efficient" hospitals. AHA data illustrate the same trend: nearly 3,500 hospitals, approximately two-thirds, lost money caring for Medicare patients in 2017. Payments that result in sustained negative margins over more than a decade cannot be considered adequate, particularly in the face of the low cost growth hospitals have kept to since 2009. Now, more than ever, an adequate margin is needed to keep pace with new life sustaining advances in medicine, evolving needs and preferences among patients and communities, and investments in new payment and delivery models.

MedPAC points to total all-payer margins as a sign of hospital profitability overall, but using an aggregate average for all U.S. hospitals can be misleading. Such averages mask financial hardships of a substantial portion of hospitals: more than one-fourth of hospitals have negative total margins, and nearly one-third have negative operating margins. In addition, individual hospital margins vary widely and are driven by a range of factors, including facility or system size and type; local payer mix; geographic location; patient demographics; services provided, both clinical and non-medical; and relationships and affiliations with other entities in the community. Furthermore, any uptick in total margins from 2016 to 2017 must be assessed in the context of broader economic trends. As news reports have noted, the U.S. stock market was strong in 2017, and hospitals, like other entities and individuals that have made investments, are benefiting from strong returns, which they are using to drive re-investments in care. However, stock markets are historically quite volatile; returns observed in 2017 have not been sustained, and cannot be expected to continue. **Given these nuances and considerations, MedPAC should not draw conclusions on hospital financial conditions from total margin aggregate averages.**

In addition, while MedPAC indicates that hospitals still have a financial incentive to take additional Medicare patients despite negative margins, this statement overlooks a stark reality for America's hospitals. Specifically, Medicare beneficiaries accounted for 45 percent of hospital discharges in 2017 and are, thus, a dominant part of hospitals' missions of serving their communities. Indeed, even the most financially vulnerable hospital cannot and will not stop taking Medicare patients. **If a hospital is in dire**

financial straits, it does not stop taking Medicare patients – it closes. And, spurred by the steady decline in Medicare margins over the past two decades, this is exactly what we have observed. As documented by the North Carolina Rural Health Research Program, 95 rural hospitals have closed since 2010, including 14 rural closures in 2018 alone. Notably, the Government Accountability Office (GAO) reported that more than twice the number of hospitals have closed between 2013 and 2017 than in the previous five-year period, indicating a worsening trend. The GAO also found that Medicare Dependent Hospitals – those rural hospitals with high proportions of Medicare days or discharges – were disproportionately represented among rural hospital closures, making up just 9 percent of rural hospitals in 2013 but 25 percent of rural closures between 2013 and 2017. Thus, the concern remains that very vulnerable rural hospitals are the "canaries in the coal mine," serving as initial indicators of a tipping point where private payers are no longer willing to fund, and hospitals can no longer sustain operations on the cost-shift that such considerable Medicare underpayments necessitate. **We urge the Commission to acknowledge that Medicare payments are inadequate and that a full market-basket increase for inpatient and outpatient hospital services is absolutely necessary.**

HOSPITAL VALUE INCENTIVE PROGRAM

As currently designed, the AHA believes there is a substantial risk that the HVIP will not improve upon the existing Medicare hospital value programs and may lead to unintended consequences that run counter to MedPAC's stated goals of driving even greater improvement in hospital performance. The AHA urges the Commission to defer a final recommendation on the HVIP and use the time to delve more deeply into many issues, such as those described below. The Commission should carefully consider whether this new program can effectively drive the improvement in outcomes all stakeholders want, assess providers fairly and minimize the potential for unintended consequences.

We agree with MedPAC that value-based programs should use a small number of rigorously designed quality measures focused on the most important opportunities to improve care. The differences in scoring approaches among the current hospital value programs can create conflicting signals to hospitals and the public on quality, even when the programs use the same measures. Too many quality measures and conflicting signals add regulatory burden that does not benefit patients or providers.

However, there are design issues with the alternative MedPAC has discussed. For example, as we understand it, the HVIP would use only five measures – all-cause, all-condition readmissions, all-cause, all-condition mortality, a composite of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures, a composite of hospital-acquired conditions (most likely infection measures), and Medicare Spending per Beneficiaries (MSPB). We appreciate MedPAC's interest in using fewer measures, and understand all of these measures reflect topics of importance to hospitals at this time. However, the hospital field's performance and the

state of measurement science continue to evolve. As health care delivery transforms, and performance on these measures improves, they may no longer represent the best opportunities for quality improvement for hospitals. Restricting the measures in the HVIP to just these topics may limit the ability of the Centers for Medicare & Medicaid Services (CMS) to incorporate more timely and relevant topics in the future. **MedPAC should consider recommending that CMS have flexibility in choosing specific measures and measure topics in the HVIP and have a process for engaging interested stakeholders in identifying which measures are well-suited to these tasks.**

The AHA also urges MedPAC to reconsider the appropriateness of using all-cause, all condition readmission and mortality measures. MedPAC has suggested that these measures are superior to the disease condition/procedure-specific measures because measure reliability likely increases as measure case volumes increase. However, many hospitals find that the condition-specific measures are more actionable because they facilitate targeting and prioritization of improvement efforts. Further, as discussed below, measure performance likely would be influenced by social risk factors (e.g., income, availability of primary care and pharmacies) that have impact on patients' recovery. Yet, neither measure is adjusted to account for these factors.

Once appropriate adjustment is incorporated, we urge MedPAC to carefully assess the risk adjustment models of these measures – especially the mortality measure – to ensure there is enough variation in risk-adjusted performance rates to warrant their use. Without question, readmission and mortality measures require robust risk adjustment approaches. But when the measured outcome is broadened, the risk adjustment models often require the inclusion of many more variables. Yet, including more variables in the models can mean that much of the performance variation becomes "explained away" by the models. There is evidence suggesting this may be the case for an all-cause, all-condition mortality measure. In 2018, the multi-stakeholder Measure Applications Partnership (MAP) was asked to review an all-cause mortality measure. The early technical report showed very little meaningful performance variation.[1] In fact, only *six* hospitals had scores that were statistically worse than average.[2]

The AHA also has concerns about how the MSPB measure would be used in the context of the HVIP. The measure is not a measure of actual cost *per se.* Rather, it is a measure of what Medicare decides to pay each hospital, physician, and post-acute care site, rolled into a single score over a 30-day timeframe. As a result, the only way to improve measure performance is to lower the utilization of services. Hospitals that treat

[1] National Quality Forum—Measure Applications Partnership. *2017-2018 Spreadsheet of Final Recommendations to HHS and CMS.* February 2018. Available at www.qualityforum.org/ProjectMaterials.aspx?projectID=75367

[2] Yale New Haven Health System Center for Outcomes Research and Evaluation. *Claims-Only Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure: Measure Methodology for Public Comment.* December 2017.

sicker patients, patients with multiple co-morbidities, or that have greater capacity to perform life-sustaining treatments for patients, such as some of the new gene therapies, or function-improving therapies (physical and occupational therapies), will have higher costs. At a minimum, before the MSPB measure should be used, MedPAC should assess: 1) the adequacy of the risk adjustment approach in MSPB; 2) the likelihood of unintended consequences from financial pressures to reduce services to patients, many of which may be beneficial; and 3) whether risk-adjusted measures of actual cost (rather than simply what Medicare sets as its payments for various services) could be developed.

Lastly, the AHA believes the use of prospective targets for performance holds promise, but urges more work to ensure any targets are equitable. As we understand it, target performance scores would be set for each measure, and hospitals would be awarded points based on percentile of performance. But how targets are set makes a significant difference in terms of how hospitals would perform. For example, teaching hospitals see sicker patients and patients with more socio-demographic challenges. These patients may have a greater risk of readmission. Would the same targets be set for teaching hospitals as for hospitals with lower acuity? Wouldn't that create a calculation that is biased against the teaching hospital? The same issue could be true of the MSPB measure. Patients treated in large referral centers may simply require more services, and therefore, have higher MSPB scores. How would you compare those hospitals to others? There is significant literature showing that nearly all of the outcomes that are measured in the HVIP can be affected by social risk factors in the communities that hospitals serve.[3] As a result, any program that includes these measures must have a methodology to account for these differences.

We appreciate that MedPAC would place hospitals into peer groups based on the proportion of dual-eligible patients they treat. This approach is a crude way to account for social risk factors and currently is used in the Hospital Readmissions Reduction Program. Yet, in selecting that method of risk adjustment in the 21st Century Cures act, Congress mandated that the Secretary maintain stratification by dual eligibility for only two years before considering other methods of adjusting for social risk that more closely align with actual experience. Congress was keenly aware that much research was underway to identify the real socio-economic drivers of differences in readmissions, such as access to primary care, access to exercise facilities and healthful food, living conditions, and other factors that could be identified and used in better risk adjustment. It would be premature for MedPAC to recommend locking in place for the HVIP program a risk adjustment methodology at a time when much better risk adjustment methods are being developed.

[3] National Academy of Medicine. *Accounting for Social Risk Factors in Medicare Payment.* January 2017.

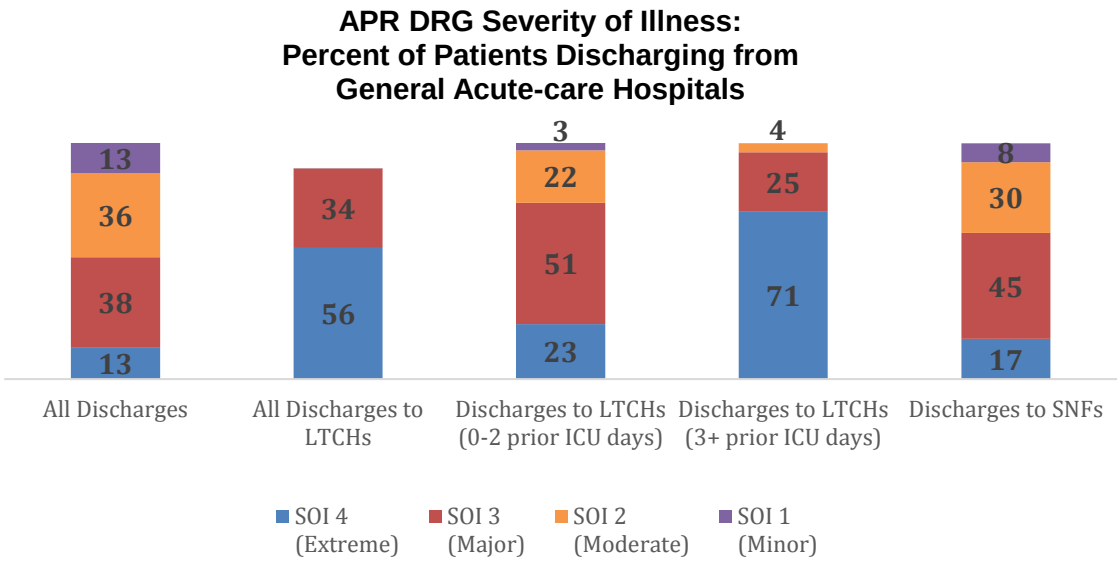
LONG-TERM CARE HOSPITALS

The AHA urges MedPAC to recommend a current law market-basket update for LTCHs in FY 2020 based on the following considerations:

- LTCHs play a unique and valuable role by targeting the highest-acuity, long-stay patients.
- LTCH site-neutral cases are being systematically underpaid, and we estimate that Medicare payments to this subgroup will decline by more than $1 billion from fiscal year 2016 through 2019.
- Both the size of the overall LTCH patient population and the number of LTCHs are decreasing due in large part to the underpayment of site-neutral cases.
- MedPAC projects a continued decrease in Medicare margins to LTCHs (1.2 percent margin in FY 2019) with further payment reductions on the horizon if its post-acute care PPS prototype is implemented in the future.

As pointed out by several commissioners during the December meeting, the rationale for eliminating the LTCH update in FY 2020 did not address the factors above. **Collectively, these variables demonstrate the magnitude of site-neutral payment's impact on the LTCH field and provide ample rationale for a current law update in FY 2020.**

The LTCH patient population has the highest rate of patients with extreme severity of illness (SOI)**. When compared to general acute hospitals and their intensive care units (ICUs), and to other post-acute settings, LTCHs treat the patient population with the highest-acuity levels.** Specifically, the table below highlights that, using the All Patients Refined Diagnosis Related Group (APR DRG) SOI scale, patients discharged to LTCHs – especially those with three or more ICU days in the prior hospital – have a far higher proportion of patients with extreme SOI (shown in blue) than the levels found in general acute-care hospitals and those discharged to SNFs. This concentration of services on the highest-acuity patient population is executed by specialized staff running targeted clinical programming for respiratory, infectious disease, and other patients with major comorbidities and complications. We also note that the LTCHs' requirement for an average length of stay of greater than 25 days requires LTCHs to focus on treating patients expected to need an extended stay, as noted by MedPAC staff during the December meeting.



LTCH site-neutral payment is reducing Medicare payments by over $1 billion. To estimate the magnitude of the impact of LTCH site-neutral payment, the AHA evaluated claims from FYs 2016 and 2017, as well as projected case volumes for 2018 and 2019. As shown below, in its first four years, the site-neutral policy is expected to reduce aggregate Medicare payments to LTCHs (when compared with what they would have received under a full standard rate payment) by more than $1.1 billion.[4]

Estimated Impact of LTCH Site-neutral Payments from FYs 2016 through 2019

Fiscal Year	Total Payments if Paid at Full Standard Rate	Total Blended Payments (50% Site-neutral/50% Standard Rate)	Difference[5]	Percent Difference
2016	$1.880 B	$1.749 B	-$131 M	-7%
2017	$1.417 B	$1.034 B	-$382 M	-27%
2018	$1.147 B	$0.808 B	-$339 M	-30%
2019	$0.910 B	$0.645 B	-$266 M	-29%
Total	**$5.354 B**	**$4.236 B**	**-$1.118 B**	**-21%**

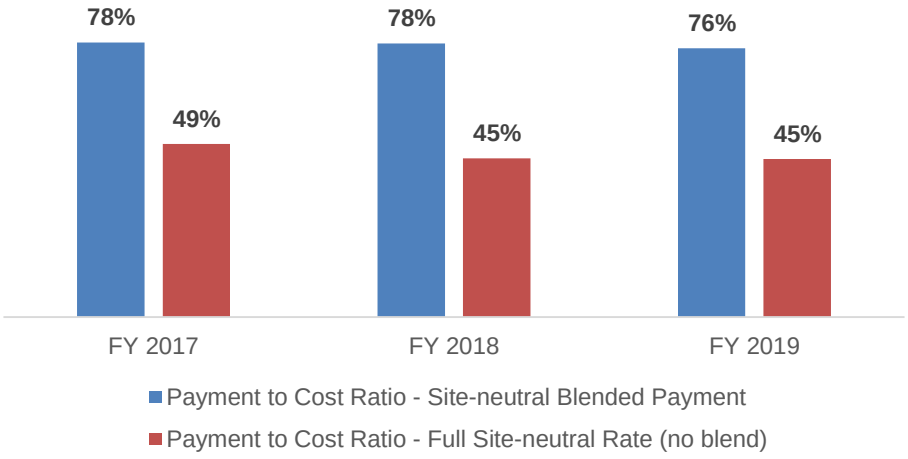
Sources: FY 2016 & FY 2017 MedPAR files; FY 2016-2018 final rule and FY 2019 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2018 update).

[4] In conducting this analysis, we assumed that site-neutral volume in FY 2018 & 2019 drops by the same percent per year as it did between FY 2016 & 2017 (approximately 20% per year). Should site-neutral volume drop by a smaller percentage, the estimated total impact shown in the table would be higher; should site-neutral volume drop by a larger percentage, the estimated impact would be lower.
[5] In FY 2016, LTCHs were paid for all discharges (including their site-neutral cases) at the LTCH PPS standard rate until the start of their first cost reporting period beginning after October 1, 2015; this accounts for the smaller difference in FY 2016 between the blended payment and the payment at the full standard rate.

The drop in total payments depicted in the chart above has contributed to the closure of 40 LTCHs – approximately 10% – over the last year, as confirmed by MedPAC staff during the December meeting.

LTCH site-neutral cases – 36 percent of all LTCH cases – are being materially underpaid at a scale that warrants an intervention to ensure that services for all beneficiaries treated in LTCHs are accurately and fairly reimbursed by the Medicare program. This underpayment is occurring for two reasons: 1) as MedPAC has pointed out, CMS is applying an unwarranted and redundant budget-neutrality cut to all site-neutral cases;[6] and 2) CMS continues to base site-neutral rates on the incorrect assumption that the acuity level and cost of care for LTCH site-neutral cases is the same as comparable inpatient PPS cases. As depicted below, this underpayment occurs both under the full site-neutral policy, with average payments covering only 45 percent of the cost of care, and under the 50/50 blended payments of the transition to full site-neutral payment, only covering an average of 76 percent of costs. The policy will be fully phased in on a rolling basis following FY 2019 cost reporting periods.

Underpayment of LTCH Site-neutral Cases, as shown by Payment to Cost Ratios; With and Without Blended Payment



Sources: FY 2017 MedPAR file; FY 2017 and 2018 final rule and FY 2019 proposed rule CMS public use files for inpatient PPS and LTCH PPS; CMS Provider Specific File (April 2018 update).

LTCH site-neutral cases are far sicker than general acute-care hospital cases but paid inpatient PPS-like rates. Contrary to CMS's projections, the acuity level and cost of care

[6] Specifically, in its May 31, 2016 comment letter on the FY 2017 inpatient PPS/LTCH PPS proposed rule, MedPAC stated that "[g]iven that the IPPS standard payment amount is already adjusted to account for [high-cost outlier] payments, CMS' proposal to reduce the site-neutral portion of the LTCH payment by a budget neutrality adjustment of 0.949 is duplicative and exaggerates the disparity in payment rates across provider settings. Given this duplication, CMS should not adjust the site-neutral rate further."

for LTCH site-neutral cases far exceed those of comparable inpatient PPS cases.[7] One key driver of the higher cost of treating site-neutral cases is that they have a higher average level of clinical acuity. Specifically, we found that 54 percent of these cases have between one and four complications and comorbidities/major complications and comorbidities (CC/MCC), while 42 percent have five or more CC/MCCs (see Chart 3 below). Compared to inpatient PPS cases (those with fewer than three days in the ICU), 62 percent have one to four CCs/MCCs, but only 12 percent have five or more. Consistent with their higher acuity levels, LTCH site-neutral cases also have an average length of stay of 25.1 days, which is much more similar to that of LTCH cases paid a standard rate than to the 4.0 day average length of stay for comparable inpatient PPS cases. The contrast is equally stark when comparing Medicare payment-to-cost ratios: 0.47 for LTCH site-neutral cases, and 0.99 for inpatient PPS cases with fewer than three ICU days.[8] Average costs per case for these cases were $32,941 and $11,190, respectively.[9] Collectively, these data, which also are presented in the chart below, show that LTCH site-neutral cases are, on average, sicker and cost three times more than inpatient PPS cases with fewer than three ICU days. Yet, the inpatient PPS-based, site-neutral rate covers less than half the cost of care.

Chart 3. LTCH Site-neutral Cases Compared To Inpatient PPS Cases with Fewer than 3 ICU Days*

	IPPS Cases with <3 ICU Days	LTCH Site-neutral Cases
Number of Cases	6,974,091	50,781
Length of Stay	4.0	25.1
% of Cases with 1-4 CC/MCCs	62%	54%
% of Cases with 5+ CC/MCCs	12%	42%
Average Cost	$11,190	$32,941
Average Medicare FFS Payment**	$11,108	$15,592
Payment to Cost Ratio	0.99	0.47

*FY 2016 cases with FY 2018 payment parameters.
**Without the site-neutral blend.

INPATIENT REHABILITATION FACILITIES

In December, the commissioners supported expediting a January vote on a recommendation to reduce FY 2020 IRF PPS payments by 5.0 percent, relative to FY 2019 payments. We urge the commissioners to reconsider this position and, instead, to recognize that FY 2020 will be a year of major transition for the IRF field due to CMS's

[7] 2016 MedPAR data.
[8] Note that overall, Medicare payments to general acute-care hospitals covered only 87 cents for every dollar spent caring for Medicare patients in 2016.
[9] FY 2016 cases with FY 2018 payment parameters.

recently finalized reforms, including recalibrating and streamlining the IRF PPS payment units known as case mix groups in FY 2020. In addition, in FY 2020 the field also will transition from well-known patient assessment metrics for functional status, which are used to set IRF PPS payments, to different metrics that are still relatively new to the field. We remind the Commissioners that IRF patient assessments and claims have historically used unique metrics, including 18 physical and cognitive elements using unique scales, while the medical records and claims that help assign patients to a payment category rely upon "etiologic diagnoses" solely used for IRFs. The upcoming changes to these unique elements require the support of IRF-specific experts and education programs.

Indeed, these two reforms are already requiring the field to undergo a major investment of resources on staff training on the assessment and coding of functional status, impact analyses and other adjustment to clinical operations. These changes will be particularly difficult for smaller providers, such as the more than 900 hospital-based units, which have a minimal Medicare margin and, thus, fewer resources available to dedicate toward preparation for these reforms. **Given the magnitude of the upcoming reforms, a market-basket reduction would needlessly exacerbate the instability caused by this complex regulatory transition – as such, we urge MedPAC to support a current law update for IRFs in FY 2020.**

HOSPITAL-BASED SKILLED NURSING FACILITIES

As noted by MedPAC, hospital-based SNFs have many attributes that policymakers are striving to make more prominent in the overall SNF field. For example, they are disproportionately represented among those SNFs with the highest shares of medically complex patients; they had notably lower shares of intensive therapy days (65 percent) compared with freestanding facilities (83 percent) in 2016; they had community discharge rates superior to those of their freestanding counterparts by 6.6 percentage points in 2013; and they had lower readmission rates by 2.1 percentage points in 2014. Further, these attributes of hospital-based SNF traits align with those that CMS seeks to encourage with the SNF PPS redesign to be implemented in FY 2020.
Specifically, the new model is expected to shift resources to hospital-based SNFs because their existing patient-mix and service profile reflects CMS's payment policy priorities. The FY 2020 reforms provide another compelling validation of the hospital-based SNF model, with its greater focus on medically-complex patients and lower utilization of therapy.

Given their alignment with policymaker goals and their historic underpayment, payments to hospital-based SNFs warrant a current law update for FY 2020 rather than an elimination of their market basket. We note that while the extremely negative Medicare margins of hospital-based SNFs (*negative* 67 percent in FY 2016) are partly due to their higher costs, they also are largely due to their higher-acuity patient mix. MedPAC has noted that this margin reflects "more staffing, higher skilled staffing, and shorter stays (over which to allocate cost)" – all of which makes sense in light of their

sicker patient population. While the new SNF PPS model will shift funds to providers treating a greater proportion of medically complex patients, the 16.7 percent payment increase estimated for hospital-based SNFs will address only a small portion of the negative margin they face.

POST-ACUTE CARE PPS-RELATED CONCERNS

Since the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was enacted, MedPAC has been conducting research that addressed the law's mandate for the development of a single PPS for the four post-acute settings: home health agencies, SNFs, IRFs and LTCHs. This work aligns with MedPAC's broader effort to increase the accuracy of post-acute care payment, a goal strongly supported by the AHA. As the Commission continues its work, we would like to reiterate critical issues and our recommendations:

- MedPAC's Post-acute Care PPS Prototype. The AHA evaluated the post-acute care PPS prototype that MedPAC issued to Congress in 2016. The evaluation report, "*A Critique of MedPAC's Post-Acute Care Prospective Payment System Prototype*," highlighted several fundamental concerns with the MedPAC prototype:
    - The model is, in part, built using very old cost data, which raises questions about the prototype's accuracy in predicting costs given the current post-acute care scenario in which all four settings are presently treating sicker patient populations, on average, due to targeted legislative and policy changes, as well as pressures from alternative payment models. We also note that significant changes for 2020 are in process, as discussed above, which will raise these setting's focus on treating medically complex cases, which could make the prototype even more dated.
    - The prototype's reliance on a 1,000 variable regression model diminishes its practical use by providers assessing admissions eligibility for incoming patients.
    - The report also raises access concerns for high-acuity, high-cost post-acute care patients whose resource are least likely to be captured by the prototype, as recognized by MedPAC, which would produce a great vulnerability for these patients if not addressed during subsequent policy-development stages.

- Accelerating Post-acute Care PPS Implementation to 2021. The MedPAC recommendation to accelerate the implementation of the post-acute care PPS to 2021 also is a cause for concern. It seemed to overlook the complexity of shifting nearly 30,000 providers to a new payment system that still is under development and lacks the extensive companion policies that would be needed to implement any brand new Medicare payment system, such as a quality reporting infrastructure, conditions of participation, etc. Again, we note that despite

inquiries from several commissioners, the recommendation still lacks a detailed explanation of how this major policy shift actually could be accomplished by Congress, CMS and other required entities.

- "Higher-quality Post-acute Care Providers." During its September 2017 and March 2018 public meetings, the Commission discussed research on encouraging beneficiaries to use "higher-quality post-acute care providers." This new metric of has not been fully explained. Rather, staff noted that it is based on a customized compilation of variables, including mortality and readmissions data. This research and this metric remain of great interest to the AHA, as it appears that any future recommendation would influence both general acute-care hospitals, as well as post-acute care providers. We continue to believe it is important for the Commission to share with stakeholders its specifications for this MedPAC-developed metric, "higher-quality PAC providers."

- Paying for Post-acute Care Services with Blended Weights. The recommendation approved by the Commission in January 2018 called for 2019 payments for the four post-acute payment systems to use a blend of relative weights that was 50 percent based on the post-acute care PPS relative weights developed by MedPAC staff. As we noted in several letters to the Commission, the MedPAC-developed post-acute care PPS relative weights were never shared with the public, which counters the Commission's commitment to transparency and prevents any external validation. We continue to request that MedPAC share with stakeholders its post-acute care PPS relative weights.

Again, 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 Erika Rogan, senior associate director of policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development