National Association for the Support of Long Term Care

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National Association for the Support of Long Term Care

September 20, 2016

The Honorable Kevin Brady
Chairman
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
United States House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

The Honorable Pat Tiberi
Chairman, Health Subcommittee
House Committee on Ways and Means
1104 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady, Representative Kind and Chairman Tiberi:

On behalf of its more than 100 member companies, the National Association for the Support of Long Term Care (NASL) once again welcomes the opportunity to provide comments to the revised draft changes to H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing Act of 2015, which would establish a new post-acute care value-based purchasing program that would apply to all home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRF) and long term care hospital (LTCH) providers, and begins in 2020.

NASL is a national trade association representing ancillary service providers to long term and post-acute care (LTPAC) settings, including information technology developers, clinical laboratory services, portable x-ray, parental and enteral supplies, equipment and nutrients and rehabilitation therapy providers. NASL member rehabilitation companies collectively employ more than 64,000 individuals providing SLP, OT and PT.

NASL supports the concept of advancing PAC value-based purchasing in Medicare. On October 15, 2015, NASL joined with several post-acute provider and community organizations to send a coalition letter to the House Ways and Means Committee leadership, where we requested several changes that should be considered with the adoption of a post-acute care value-based purchasing (PAC-VBP) Program. We were pleased that some of the recommendations provided by the PAC providers were incorporated in the proposed bill changes to H.R. 3298. NASL joined with the PAC coalition in sending a September 15, 2016, letter which outlines our recommended changes that we believe must be included as part of any PAC VBP program, based on the proposed modifications that were reflected in the Committee's Green Sheet. NASL's priorities for further refining H.R. 3298 are reflected below:

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1. Application of Quality and Resource Use Measures

The PAC VBP program relies on resource use measures, including the Medicare Spending Per Beneficiary (MSPB) measure that was specified in the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*. The PAC VPB Program is largely based on this measure until a second measure is added by 2021. We are concerned that the PAC VBP would be based on a measure that is extremely complex and which combines various inclusions and exclusions and a complicated episode. Providers were given only two weeks and two days to absorb and comment on the measure in January. Since that overly condensed comment period, there has been one 68-page report released in July on the CMS website that lists the measure specifications. Data collection on quality and resource use measures-- including the MSPB -- begins October 1, 2016 for SNFs. Because data collection is just beginning in a few days, and the measure specification is overly complex, the SNF community has not had an opportunity to accumulate data or experience in how the MSPB data will be reflected in the measures. We have no experience on this complex measure and therefore, if we accept the MSPB measure along with the potential cuts that come with the PAC VBP, we would be agreeing to a program without any experience in the measure and the measure's potential shortcomings.

Additionally, we believe basing a PAC VBP on just one measure is not enough. We appreciate that a functional change measure was added in the Green sheet language, although this will begin several years into the program. A program based on one measure (MSPB), even for the first two years, is akin to "all eggs in one basket." We believe strongly that providers need multiple areas in which to accurately demonstrate their performance. For this reason, NASL supports implementation of the *IMPACT Act*'s mandated quality and resource use measures prior to overlaying a PAC VPB Program that would withhold reimbursement based on these measures.

2. Ensure the VBP Program is Budget Neutral

As currently proposed, the Committee's goal is to make the entire bill budget-neutral by using the Medicare Improvement Fund (MIF) as a depository for the savings extracted from each PAC payment system. However, there are no assurances that the MIF money will be redistributed proportionally or fairly across PAC provider types. We believe that the entire withhold should be redistributed and not to potentially other components of the Medicare program. Importantly, we also urge the Committee to limit the PAC VBP withhold to 2% and phase in the withhold by the fifth year of the program.

3. Minimize the Latitude Given to the Secretary to Implement VBP PAC program

We are concerned that the legislation provides the Secretary with very broad discretion as to how the performance standards, performance scores and ultimately the performance rankings are developed. Our general concern is based on our experience over the last year as CMS has had latitude to develop measures with extremely short

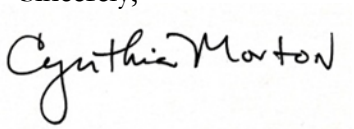
comment periods, such as two weeks. If these measures are to be the 'bedrock" for the PAC VPB withhold Program, then it is essential that the Secretary take the appropriate amount of time to ensure that the measures are built accurately and appropriately, with meaningful time for stakeholder input. Rushing to develop this foundation of the program will cause many problems later that will be tougher to fix. When significant latitude is provided we are concerned that stakeholder involvement will be minimal.

4. Define "Hospital Referral Area" for PAC Performance Scores

The revised draft replaces "service area" with "referral area" for the development of a methodology for assessing the total performance of each PAC provider, and of each hospital referral area or comparable area. The Secretary will determine the process, based on performance standards and the measures applied for a performance period for a payment year. The bill does not define what a hospital referral area is, and we urge that this term be defined in the legislation. We presume it has to do with defining a market. Other programs use MSAs. It is important that providers know who they are being compared against in the rankings.

NASL members appreciate your leadership in championing the PAC VBP legislation, and allowing the PAC provider community to address our fundamental concerns with H.R. 3298. We look forward to meeting with you or members of your staff to further address the recommendations that have been shared in our comments. If you have any questions, please do not hesitate to contact me at (202) 803-2385 or Cynthia@NASL.org.

Sincerely,



Cynthia Morton, MPA
Executive Vice President