September 15, 2016

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

The Honorable Ron Kind
U.S. House of Representatives
1502 Longworth House Office Building
Washington, D.C. 20515

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

Dear Chairman Brady, Rep. Kind, and Chairman Tiberi:

On behalf of the post-acute care (PAC) and provider community, we appreciate your continued leadership in promoting innovations in the payment and delivery of PAC services. We also want to thank you and your staff for engaging stakeholders in developing and refining H.R. 3298, the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015*. While we remain committed to advancing PAC value-based purchasing (VBP) in Medicare, we are unable to support the legislation in its current form, given that many of the necessary changes we recommended in writing last October have yet to be incorporated into the revised bill.

As you advance quality reforms in the PAC sector, we offer the following requested changes and principles that must be included as part of any PAC VBP program. Should these revisions be made, we will be better able to achieve support from our respective memberships. If these changes are not made, we will be left with no choice but to oppose the legislation.

1. VBP scores should be focused on patient outcomes, not resource use.

H.R. 3298 places too great an emphasis on resource use. We strongly urge you to include a narrow set of meaningful outcomes measures, which are validated for each PAC setting, and reduce the percentage of the composite performance score attributed to resource use. Under the proposed bill revisions, for the first two years, PAC providers would be judged solely on resource use. In year three, when the program in the bill is fully implemented, providers would be judged on just two scores: resource use and functional status. By comparison, the Hospital VBP involves seventeen measures: 8 process, 7 outcomes, 1 satisfaction and 1 resource use.

We strongly urge that you condition no more than ten percent of a provider's score on its resource use. Implementation of a PAC VBP program should be delayed until the outcomes measures, called for by the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*, are implemented and shown to be good indicators of quality.

One aspect common in VBP programs is the recognition of provider improvement. The revised legislation removes the requirement that PAC VBP providers be able to receive bonus payments for improving their quality scores. We ask that this requirement be restored.

Finally, initiation of PAC services should be the trigger of the episode for efficiency measurement purposes. For the purposes of resource use, PAC providers should not be held accountable for expenditures that occur during the acute care hospitalization that precedes the PAC service that triggers an episode.

2. Post-acute care payment reform should be informed by the evidence: Wait for the appropriate cross-setting IMPACT Act measures to be fully-implemented.

The IMPACT Act established a detailed process through which critically important data and standardized information will be collected, published, and analyzed on a cross-setting basis among PAC providers. The IMPACT Act calls for reports on PAC payment reforms from both CMS and the Medicare Payment Advisory Commission after the data has been sufficiently collected in each PAC setting. These analyses of the data could set the stage for significant future changes to PAC care practices and existing PAC payment policies. Specifically, patients could end up being served in

different care settings than they are today and it is important that the VBP model not be based on outdated practices that might no longer exist. That is why we believe it is important for the process required under the IMPACT Act to be carried out in accordance with the law's specified timeline. We strongly urge that changes be made to H.R. 3298 so that it adheres to the IMPACT Act's implementation timeline, thereby ensuring that the cross-setting measures that would be necessary for implementing this legislation have been fully developed, validated and vetted.

3. Post-acute care payment reform should facilitate patient access to the appropriate specific PAC provider type they need: Make the PAC VBP program budget-neutral.

We strongly urge you to make any PAC VBP program budget-neutral within each provider payment system – just like the Hospital VBP program is budget-neutral within the inpatient prospective payment system. While we appreciate your desire to offer regulatory relief to PAC providers, we feel that such an effort is a separate endeavor from a PAC VBP design, and thus warrants its own discussion separate and apart from PAC VBP. A PAC VBP program should be focused solely on improving care quality and the best way to do that is to reinvest all withheld payments in the form of incentive payments to be redistributed into the particular payment system from which they came.

While our suggestion to make the program budget-neutral would eliminate the need for savings to be deposited into the Medicare Improvement Fund (MIF), we would be remiss if we did not express our strong reservations about the MIF provision in the current bill. While your stated goal is to make the entire bill budget-neutral by using the MIF as a depository for the savings extracted from each PAC payment system, there are no assurances that the MIF money will be redistributed proportionally or fairly across PAC provider types. In fact, it would be nearly impossible to do so via additional regulatory relief provisions because it would be difficult to accurately calibrate and harmonize the costs of PAC payment system-specific regulatory relief with payment-specific withhold amounts.

4. Make the payment withhold percentage fair and consistent with other VBP programs.

We strongly urge you to bring fairness to the withhold percentage by making it consistent with the Hospital VBP program. Specifically, we ask the PAC VBP withhold percentage be as follows:

*Year 1: 1% *Year 2: 1.25% *Year 3: 1.5% *Year 4: 1.75% *Year 5: 2%

Such a phase-in schedule and capped withhold percentage are identical to the Hospital VBP program. It is important to note that acute care hospitals have more than a decade of experience reporting to the Centers for Medicare & Medicaid Services (CMS) on

quality measures, while both quality measures and reporting are very recent developments for the PAC sector, thereby highlighting the need for a patient and reserved implementation approach. It should also be noted that the skilled nursing facility (SNF) VBP program puts two percent of SNF Medicare rates at risk.

Further, the purpose of a VBP program is to incentivize providers to change behaviors to achieve the best patient outcomes. Experiences to date indicate that PAC provider behaviors will adjust without imposing significant financial risk. In addition, if too much is placed at risk, PAC providers will be deprived of the resources needed to improve performance.

It has been contended that the currently drafted five percent PAC VBP withhold is valid because hospitals have a total of 8 percent of their Medicare payments at risk across four separate initiatives impacting hospital inpatient payments. We feel that this is an inappropriate comparison for a number of reasons. First, this 8 percent withhold does not apply to all hospital payments — tens of billions of dollars (more than $40 billion in 2015) of hospital outpatient payments are exempt from this 8 percent withhold. Second, not all of this eight percent is at risk. For example, under the Electronic Health Record Incentive Program, if a hospital attests that it "meaningfully uses" health information technology, the hospital is not at risk for that portion of the payment percentage cited above, which amounts to 2.025 percent in FY17. This payment percentage is therefore not performance-based ("at risk"). Third, many of these hospital payment programs were included as part of the deal the industry made during passage of the Affordable Care Act. Hospitals anticipated they would benefit from an increase in insured patients and a decrease in uncompensated care. In this case, they could afford to put a portion of their Medicare payments at risk to help fund the Medicaid and Exchange coverage expansion. Lastly, it took years before acute hospitals' payments were put at risk and that only followed after years of experience reporting on quality measures and adjusting practice patterns and processes to account for such measures.

5. Patients should have equitable access to post-acute services nation-wide: Remove geographic resource use comparison.

We strongly urge you to remove any comparison of PAC providers' resource use between any geographic areas. The Institute of Medicine recommends that Congress not use a geographically based resource use index, saying that it would "unfairly reward low-value providers in high-value regions and punish high-value providers in low-value regions."[1] If too much attention is placed on provider costs, providers and

[1] INSTITUTE OF MEDICINE. THE STUDY OF GEOGRAPHIC VARIATION IN HEALTHCARE SPENDING AND PROMOTION OF HIGH VALUE CARE (2013).

beneficiaries in some areas of the country will be at a significant disadvantage because of variations in labor and property costs, regardless of the quality of care they are providing. Additionally, the PAC continuum is currently comprised of four provider types – home health, skilled nursing facilities, rehabilitation hospitals and long-term acute care hospitals. These providers are distinct and their costs or resource use should not be compared with one another.

Further, areas where long-term care hospitals and inpatient rehabilitation facilities, which receive higher average Medicare reimbursements, will naturally have higher spending than areas that do not have these facilities. Providers should not be punished or rewarded simply because of the provider mix in their geographic-area particularly since many states have procedures in place to determine the need for these facilities.

We appreciate your consideration of our proposed modifications to H.R. 3298 and look forward to working with you and your staff on this legislation. In addition, individual association members of our coalition may file separate comments specific to their sectors.

The PAC provider community supports the concept of a fairly designed PAC VBP and looks forward to working with the Committee to address our fundamental concerns.

Sincerely,

American Health Care Association
American Medical Rehabilitation Providers Association
LeadingAge
National Association for Home Care & Hospice
National Association for the Support of Long Term Care
National Association of Long Term Hospitals
National Center for Assisted Living
Partnership for Quality Home Healthcare
Visiting Nurse Associations of America