AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

Statement for the Record

House Ways and Means Health Subcommittee

The Evolution of Quality in Medicare Part A

September 16, 2016

On behalf of 18,000 board-certified orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) would like to commend House Ways and Means Health Subcommittee Chairman Patrick Tiberi (R-OH), Ranking Member James McDermott (D-WA), and all other committee members for holding the hearing titled "The Evolution of Quality in Medicare Part A."

In Chairman Tiberi's opening remarks, he stressed his intention to improve the Medicare Part A program in an effort to improve the quality of care for Medicare patients. The Chairman emphasized the importance of reforming the system to ensure that quality is incentivized and cost-efficient, noting that last year Congress reformed the way Medicare pays physicians, and now, "this Committee is continuing that effort by looking at the Medicare Part A or hospital system." Importantly, Chairman Tiberi also stressed the regulatory challenges that exist and that distract from patient care.

While the hearing did not directly address physician-owned hospitals (POHs), we want to highlight the fact that these hospitals represent exactly the kind of high value/high quality care that Chairman Tiberi described. Unfortunately, nearly all POHs (although the average level of ownership per physician is less than 2 percent), are restricted from new construction or expansion due to provisions in the Affordable Care Act (ACA).

The inability of POHs to meet their community's fast-growing demand for high-quality health services is bad for patients, and in particular those on Medicare and Medicaid. Current law is forcing these low-cost centers of excellence to consider forfeiting their Medicare license in order to add desperately needed capacity and remain accessible to patients in the community. These restrictions also interfere with physician autonomy, patient choice, and the doctor-patient relationship.

Quality: These hospitals are superior in terms of quality, value, and access. They consistently rank higher under current quality measures when compared to other hospitals. The also provide some of the best care at the lowest cost. In fact, more than 40 percent of POHs received the top 5 star rating from the Centers for Medicaid and Medicare Services while only 5 percent of general hospitals did. Furthermore, Consumer Reports said that POHs are more efficient and have higher quality patient outcomes.

Value: POHs are not just providing high-quality care and contributing to local economies – they are saving the government money. A new study by Avalon Health Economics found the POHs are

317 Massachusetts Avenue NE
Suite 100
Washington, D.C. 20002-5701
PHONE 202.546.4430
www.aaos.org/dc

saving Medicare $3.2 billion over 10 years. The average payment rate for hospitals with physician ownership is substantially less than the average payments to non-POHs for the same services.

Access: The inability of POHs to address growing demand, especially in rural areas, is bad for our entire health care system and penalizes patients who deserve the right to receive care at the hospital of their choice. These restrictions are particularly discriminatory towards Medicare and Medicaid patients who may not have the means or mobility to find other options. Further, without the ability to expand, many POHs are considering dropping Medicare and Medicaid completely. Ironically, this means this particular ACA provision has resulted in the opposite of the law's original intent of increasing access.

Opponents of POHs have accused them of "cherry-picking" patients. A comprehensive, peer-reviewed study of all POHs recently published in the highly regarded British Medical Journal concluded that POHs see the same patients as hospitals without physician ownership. According to the study, POHs have virtually identical proportions of Medicaid patients and racial minorities. And the communities in which POHs operate are as diverse as the country itself.

Additionally, physician-owned hospitals have injected much-needed competition into the hospital market, encouraging all hospitals to improve and innovate. They drive higher quality and improved outcomes for patients.

H.R. 2513, introduced by Reps. Sam Johnson (R-TX) and Ruben Hinojosa (D-TX), would allow these high-quality hospitals to expand if they have received at least 3 stars in the Hospital Compare star rating program for 3 consecutive years. This bipartisan legislation would positively impact approximately 235 hospitals across 33 states. AAOS strongly supports H.R. 2513 and the ability for physician-owned hospitals to grow and compete like every other type of hospital. This would be a win for patients and for the entire health care system as we work to improve care in the Medicare Part A program and beyond.

Again, we would like to thank Health Subcommittee Chairman Tiberi and Ranking Member McDermott for holding this hearing. Because it is consistent with the purpose of the hearing, we urge committee action on H.R. 2513, which is supported by over 40 medical specialties, before the end of the 114th Congress.

Sincerely,

Gerald R. Williams JR., MD
President, American Association of Orthopaedic Surgeons

American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

"The Evolution of Quality in Medicare Part A"

September 7, 2016

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Ways and Means Committee hearing on the evolution of quality in Medicare Part A. We are pleased that the committee is interested in assessing the experience of hospitals in Medicare quality performance programs as it considers future payment reform efforts, including those intended for post-acute care providers. America's hospitals are strongly committed to transparency and the sharing of meaningful, accurate information on quality performance for hospitals and other providers. We also believe that well-designed pay-for-performance programs can support the field's ongoing transformation to value-based care.

Informed by more than a decade of experience with quality measurement and pay-for-performance in Medicare, we offer several recommendations to enhance existing hospital quality reporting and pay-for-performance programs so they more effectively drive the improvement in outcomes and health that all stakeholders – patients, policymakers and hospitals – want to see. Specifically:

- The measures used in Medicare quality reporting and payment programs should be streamlined to focus on the highest priority quality issues;

- The Hospital Readmissions Reduction Program (HRRP) should incorporate socioeconomic adjustment; and

- The Hospital-Acquired Conditions Reduction Program (HACRP) should be reformed to provide a fairer, more effective incentive to improve performance.

In addition, the AHA recommends changes to existing pay-for-performance legislation for post-acute care providers to achieve the appropriate balance between lower cost and better care.

MOVING TO MEASURES THAT MATTER

More than 10 years ago, hospitals began to voluntarily report key quality and safety data to the public. We started with 10 well-defined and scientifically proven measures of heart attack, heart failure and pneumonia that were intended to grow over time to become a set of measures that provided an important window into the quality of care provided to hospital inpatients. The Congress then linked reporting on this voluntary effort to Medicare payment incentives. The Centers for Medicare & Medicaid Services (CMS) has rapidly expanded the number of measures hospitals are required to report. These data are displayed on the *Hospital Compare* website and used by CMS in many of its pay-for-performance programs for hospitals, including the Hospital Value-Based Purchasing (VBP) Program, HRRP and HACRP. States, private payers and a variety of other organizations also request data from hospitals and seek to rate and rank hospitals' performance, as well as engage hospitals and their medical staffs in quality improvement efforts.

Hospitals continue to strongly support transparency on quality. However, there are significant concerns that the explosion in measure reporting requirements is limiting the effectiveness of efforts to improve quality and causing confusion for the public. For example, in 2019 hospitals will have more than 90 measures in CMS hospital quality reporting and pay-for-performance programs – a fact that underscores the need to further streamline measures. Further, many of CMS's chosen measures are not related to issues that are the most pressing opportunities for patient improvement. These measures increase the burden of collecting data without adding commensurate value for patients. Compounding the dilemma, private payers and other regulatory bodies require the reporting of yet additional measures. As a result, hospitals are spending time interpreting measure requirements and gathering data that could otherwise be spent on improving care.

Many hospital leaders and clinicians also are frustrated by the multitude of hospital report cards, each of which uses different measures and methodologies for rating performance. Most recently, CMS introduced "star ratings" for acute care hospitals on *Hospital Compare*. **The AHA thanks the Congress for urging CMS to make improvements to hospital star ratings, and we will continue to urge CMS to adopt a less biased, more meaningful approach.** Hospital star ratings, like movie or restaurant ratings, give hospitals one to five stars based on performance on a select subset of measures. However, the star ratings raise far more questions than answers and add to a long list of conflicting rating and ranking systems. Hospitals are especially troubled that

the current rating scheme used by CMS unfairly disparage teaching hospitals and those serving higher numbers of the poor.

The AHA believes it is time to streamline and focus the measures used in national quality measurement programs on measures that truly matter to driving better outcomes and health for the patients we serve. To provide a starting point, the AHA has engaged hospital leaders in ongoing discussions on which measurement topics they believe are the highest priority for improving care. In 2013 and 2014, the association's governance committees discussed and prioritized measurement topics for use in assessing and incentivizing hospitals and health care systems. The AHA Board of Trustees then approved a list of 11 hospital quality performance priority topics that were identified through this work. In response to subsequent feedback, the AHA Board adopted minor updates to the list of priority measure topics in July 2016. We believe CMS should use these 11 priority areas to remove measures that no longer add value and to target areas that are currently unaddressed by CMS's reporting programs. The AHA's 11 measurement priority areas are listed below.

AHA Measurement Priority Areas

- Patient Safety Outcomes
  - Harm Rates
  - Infection Rates
  - Medication Errors
- Readmission Rates
- Risk Adjusted Mortality
- Effective Patient Transitions
- Diabetes Control
- Obesity
- Adherence to Guidelines for Commonly Overused Procedures
- End-of-Life Care According to Preferences
- Cost per Case or Episode of Care
- Behavioral Health
- Patient Experience of Care / Patient Reported Outcomes of Care

To better focus the debate over quality measures and ensure that national quality goals are being advanced through measurement, the AHA believes it is important to develop a set of strategic principles that establish the parameters for "measures that matter." As such, the AHA supports the following principles for measures to be used in public reporting and incentive programs:

1. Provider behavior must influence the outcome(s) being measured;
2. Measures must have strong evidence that their use will lead to better care and outcomes;

3. Measures should be used in programs only if they reveal meaningful differences in performance across providers, although some may be retained or re-introduced to reaffirm their importance and verify continued high levels of importance;
4. The measures should be administratively simple to collect and report, and to the greatest extent possible, be derived from electronic health records data;
5. Measures should seek to align the efforts of hospitals, physicians and others along the care continuum, and align with the data collection efforts of the other providers;
6. Measures should align across public and private payers to reduce unnecessary data collection and reporting efforts; and
7. Risk adjustment must be rigorous and account for all factors beyond the control of providers, including socioeconomic factors where appropriate. In addition, adjustment methodologies should be published and fully transparent.

Lastly, the AHA believes that patients' interests will be better served if hospital measurement priorities are aligned with those for other health care providers to ensure all parts of the system are working in coordinated fashion to drive improvement. For this reason, the AHA has urged CMS and other national public and private entities to use the recommendations of the National Academy of Medicine's (NAM) *Vital Signs* report. *Vital Signs* is a unifying framework that identifies 15 core measurement priorities common to all stakeholders in health — providers, public and private payers, public health agencies and patients. These 15 areas dovetail well with the AHA's list of 11 hospital performance priorities.

IMPROVING MEDICARE HOSPITAL PAY-FOR-PERFORMANCE

The Affordable Care Act (ACA) significantly raised the financial stakes of quality measurement by introducing three "pay-for-performance" programs tying payment to the level of quality performance. The VBP Program and HRRP began affecting hospital inpatient prospective payment system payments in fiscal year (FY) 2013, while the HACRP began in FY 2015. To date, hospitals have incurred nearly $1.9 billion of readmissions penalties and $737 million in HAC penalties.

The AHA generally supports the hospital VBP program because it rewards hospitals for both performance achievement and performance improvement over time. Importantly, this program is budget neutral, which means that hospitals do not lose payment unless their performance is subpar. However, we have significant concerns about the HRRP and HACRP and have urged several reforms to improve their fairness and effectiveness.

Readmission Penalties. The AHA has long urged that the HRRP incorporate socioeconomic adjustment to ensure that hospitals caring for our nation's most vulnerable patients are not disproportionately penalized. **We strongly support the bipartisan, bicameral Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688) and are pleased a version of this bill passed the House of Representative in June 2016.**

Since the HRRP's inception, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In FY 2017, nearly 86 percent of hospitals in the highest quartile of disproportionate patient percentage (DPP) received a penalty, compared to 60 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available data on socioeconomic status, such as Medicare claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. If H.R. 1343/S. 688 is passed, CMS would be required to use these data to adjust penalties, providing important relief.

The AHA also urges CMS to exclude from the HRRP readmissions unrelated to the initial reason for admission. Despite the fact that the ACA requires CMS to exclude unrelated readmissions, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

Improving the HACRP. America's hospitals are deeply committed to reducing preventable patient harm. **However, the HACRP is poorly designed and imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for the sickest patients.** The AHA will work with CMS, Congress and others to improve existing policy and promote alternatives to the HAC program that more effectively promote patient safety.

The HACRP has several critical flaws. First, the program's arbitrary design penalizes 25 percent of all hospitals each year, regardless of significant performance improvement, and it does not measure meaningful differences in quality. Indeed, the difference in HAC scores for penalized and non-penalized hospitals in FY 2015 is hundredths of a point. Second, data show that hospitals treating complex patients are disproportionally penalized, in part because the HACRP uses claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details of a patient's risk factors and course of care. We have urged CMS to remove PSIs gradually from the HACRP. Third, some small hospitals have too few patients to have data on the two infection measures used in this program. These hospitals are assessed only on the unreliable PSIs. Finally, the HAC measures overlap with the measures in the VBP Program, yet each program uses different performance periods. This can lead to excessive payment penalties and confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that the Administration use measures in either the VBP or the HAC program, but not in both.

MOVING PAY-FOR-PERFORMANCE INTO POST-ACUTE CARE

Given the widespread use of pay-for-performance in Medicare for hospitals and physicians, policymakers have begun to express an interest in adopting pay-for-performance programs for post-acute care providers. Last year, the House introduced, H.R. 3298, the Medicare Post-Acute

Care Value-Based Purchasing (PAC VBP) Act of 2015, which would repeal the FY 2018 market-basket update cap for post-acute care providers mandated by the Medicare Access and CHIP Reauthorization of 2015, and replace it with a PAC VBP program. **In concept, the AHA agrees with the potential for pay-for-performance to accelerate improvements in post-acute care. However, we urge a number of improvements to H.R. 3298, as we are concerned that the bill too narrowly focuses on reducing provider payment rather than promoting "value" – that is, the delivery of consistently high-quality care at a lower cost.**

The AHA urges Congress to reconsider the non-budget neutral design of H.R. 3298. The PAC VBP program would withhold a percentage of post-acute care provider payments. Individual providers could earn back some or all of the withheld funds – and potentially earn a bonus – based on their performance. However, the program is not budget neutral – only 50 to 70 percent of the withheld funds could be paid back to providers, with the rest being retained by Medicare as savings. The AHA does not support utilizing VBP to achieve reductions in the Medicare program; the PAC VBP program should be budget neutral.

Moreover, we urge that any PAC VBP effort use a combination of cost and quality measures, rather than focusing on cost alone. AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. The AHA believes pay-for-performance programs should include both cost *and* quality measures to ensure that the reward system encourages both high-quality care and lower costs. Those measures should be broader than just Medicare spending per beneficiary (MSPB) and a single quality measure (functional status); additional quality metrics should be included. Without a more balanced, budget-neutral approach that includes an assessment of quality, the PAC VBP program appears to function as a mechanism to cut provider payments in perpetuity, rather than primarily as a way to promote value.

Furthermore, the proposed PAC VBP scoring methodology would tie too much of an individual provider's performance to the actions of other providers that are beyond their control. The intent of the scoring methodology appears to be to encourage collaboration among providers. However, we believe there are more appropriate and effective ways to encourage collaboration, such as assessing costs during an episode of care or setting performance benchmarks for individual providers that partially reflect a geographic area. In addition, we note that any measures used in PAC VBP should be assessed for the impact of socioeconomic factors on performance; socioeconomic adjustment should be employed when needed.

Lastly, the AHA believes the PAC VBP's payment withhold should be in step with those of other Medicare VBP programs. Indeed, the hospital VBP program, the End-Stage Renal Disease Quality Improvement Program, and skilled-nursing facility VBP program all have maximum withholds of no more than 2.0 percent. Furthermore, post-acute care providers already face numerous regulatory and statutory payment reductions and restrictions in recent years – such as site-neutral payment for long-term care hospitals, the "60 percent rule" for inpatient rehabilitation facilities, and re-basing cuts for home health agencies, to name a few. Post-acute care providers also have 2.0 percent of their payments at risk for meeting extensive quality measure reporting requirements. The cumulative impact of these policies is making it significantly more challenging for these providers to serve their patients and communities.

CONCLUSION

Despite the significant challenges with existing quality measurement and pay-for-performance programs, hospitals are making important progress in improving care, as discussed in the AHA brief, "Zeroing in on the Triple Aim." By streamlining and focusing on "measures that matter," enhancing the fairness of pay-for-performance and aligning improvement across the care continuum, we believe our nation can greatly accelerate improvements in outcomes and health.

American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives

"The Evolution of Quality in Medicare Part A"

September 7, 2016

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Ways and Means Committee hearing on the evolution of quality in Medicare Part A. We are pleased that the committee is interested in assessing the experience of hospitals in Medicare quality performance programs as it considers future payment reform efforts, including those intended for post-acute care providers. America's hospitals are strongly committed to transparency and the sharing of meaningful, accurate information on quality performance for hospitals and other providers. We also believe that well-designed pay-for-performance programs can support the field's ongoing transformation to value-based care.

Informed by more than a decade of experience with quality measurement and pay-for-performance in Medicare, we offer several recommendations to enhance existing hospital quality reporting and pay-for-performance programs so they more effectively drive the improvement in outcomes and health that all stakeholders – patients, policymakers and hospitals – want to see. Specifically:

- The measures used in Medicare quality reporting and payment programs should be streamlined to focus on the highest priority quality issues;

- The Hospital Readmissions Reduction Program (HRRP) should incorporate socioeconomic adjustment; and

- The Hospital-Acquired Conditions Reduction Program (HACRP) should be reformed to provide a fairer, more effective incentive to improve performance.

In addition, the AHA recommends changes to existing pay-for-performance legislation for post-acute care providers to achieve the appropriate balance between lower cost and better care.

MOVING TO MEASURES THAT MATTER

More than 10 years ago, hospitals began to voluntarily report key quality and safety data to the public. We started with 10 well-defined and scientifically proven measures of heart attack, heart failure and pneumonia that were intended to grow over time to become a set of measures that provided an important window into the quality of care provided to hospital inpatients. The Congress then linked reporting on this voluntary effort to Medicare payment incentives. The Centers for Medicare & Medicaid Services (CMS) has rapidly expanded the number of measures hospitals are required to report. These data are displayed on the *Hospital Compare* website and used by CMS in many of its pay-for-performance programs for hospitals, including the Hospital Value-Based Purchasing (VBP) Program, HRRP and HACRP. States, private payers and a variety of other organizations also request data from hospitals and seek to rate and rank hospitals' performance, as well as engage hospitals and their medical staffs in quality improvement efforts.

Hospitals continue to strongly support transparency on quality. However, there are significant concerns that the explosion in measure reporting requirements is limiting the effectiveness of efforts to improve quality and causing confusion for the public. For example, in 2019 hospitals will have more than 90 measures in CMS hospital quality reporting and pay-for-performance programs – a fact that underscores the need to further streamline measures. Further, many of CMS's chosen measures are not related to issues that are the most pressing opportunities for patient improvement. These measures increase the burden of collecting data without adding commensurate value for patients. Compounding the dilemma, private payers and other regulatory bodies require the reporting of yet additional measures. As a result, hospitals are spending time interpreting measure requirements and gathering data that could otherwise be spent on improving care.

Many hospital leaders and clinicians also are frustrated by the multitude of hospital report cards, each of which uses different measures and methodologies for rating performance. Most recently, CMS introduced "star ratings" for acute care hospitals on *Hospital Compare*. **The AHA thanks the Congress for urging CMS to make improvements to hospital star ratings, and we will continue to urge CMS to adopt a less biased, more meaningful approach.** Hospital star ratings, like movie or restaurant ratings, give hospitals one to five stars based on performance on a select subset of measures. However, the star ratings raise far more questions than answers and add to a long list of conflicting rating and ranking systems. Hospitals are especially troubled that

the current rating scheme used by CMS unfairly disparage teaching hospitals and those serving higher numbers of the poor.

The AHA believes it is time to streamline and focus the measures used in national quality measurement programs on measures that truly matter to driving better outcomes and health for the patients we serve. To provide a starting point, the AHA has engaged hospital leaders in ongoing discussions on which measurement topics they believe are the highest priority for improving care. In 2013 and 2014, the association's governance committees discussed and prioritized measurement topics for use in assessing and incentivizing hospitals and health care systems. The AHA Board of Trustees then approved a list of 11 hospital quality performance priority topics that were identified through this work. In response to subsequent feedback, the AHA Board adopted minor updates to the list of priority measure topics in July 2016. We believe CMS should use these 11 priority areas to remove measures that no longer add value and to target areas that are currently unaddressed by CMS's reporting programs. The AHA's 11 measurement priority areas are listed below.

AHA Measurement Priority Areas

- Patient Safety Outcomes
  - Harm Rates
  - Infection Rates
  - Medication Errors
- Readmission Rates
- Risk Adjusted Mortality
- Effective Patient Transitions
- Diabetes Control
- Obesity
- Adherence to Guidelines for Commonly Overused Procedures
- End-of-Life Care According to Preferences
- Cost per Case or Episode of Care
- Behavioral Health
- Patient Experience of Care / Patient Reported Outcomes of Care

To better focus the debate over quality measures and ensure that national quality goals are being advanced through measurement, the AHA believes it is important to develop a set of strategic principles that establish the parameters for "measures that matter." As such, the AHA supports the following principles for measures to be used in public reporting and incentive programs:

1. Provider behavior must influence the outcome(s) being measured;
2. Measures must have strong evidence that their use will lead to better care and outcomes;

3. Measures should be used in programs only if they reveal meaningful differences in performance across providers, although some may be retained or re-introduced to reaffirm their importance and verify continued high levels of importance;
4. The measures should be administratively simple to collect and report, and to the greatest extent possible, be derived from electronic health records data;
5. Measures should seek to align the efforts of hospitals, physicians and others along the care continuum, and align with the data collection efforts of the other providers;
6. Measures should align across public and private payers to reduce unnecessary data collection and reporting efforts; and
7. Risk adjustment must be rigorous and account for all factors beyond the control of providers, including socioeconomic factors where appropriate. In addition, adjustment methodologies should be published and fully transparent.

Lastly, the AHA believes that patients' interests will be better served if hospital measurement priorities are aligned with those for other health care providers to ensure all parts of the system are working in coordinated fashion to drive improvement. For this reason, the AHA has urged CMS and other national public and private entities to use the recommendations of the National Academy of Medicine's (NAM) *Vital Signs* report. *Vital Signs* is a unifying framework that identifies 15 core measurement priorities common to all stakeholders in health — providers, public and private payers, public health agencies and patients. These 15 areas dovetail well with the AHA's list of 11 hospital performance priorities.

IMPROVING MEDICARE HOSPITAL PAY-FOR-PERFORMANCE

The Affordable Care Act (ACA) significantly raised the financial stakes of quality measurement by introducing three "pay-for-performance" programs tying payment to the level of quality performance. The VBP Program and HRRP began affecting hospital inpatient prospective payment system payments in fiscal year (FY) 2013, while the HACRP began in FY 2015. To date, hospitals have incurred nearly $1.9 billion of readmissions penalties and $737 million in HAC penalties.

The AHA generally supports the hospital VBP program because it rewards hospitals for both performance achievement and performance improvement over time. Importantly, this program is budget neutral, which means that hospitals do not lose payment unless their performance is subpar. However, we have significant concerns about the HRRP and HACRP and have urged several reforms to improve their fairness and effectiveness.

Readmission Penalties. The AHA has long urged that the HRRP incorporate socioeconomic adjustment to ensure that hospitals caring for our nation's most vulnerable patients are not disproportionately penalized. **We strongly support the bipartisan, bicameral Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688) and are pleased a version of this bill passed the House of Representative in June 2016.**

Since the HRRP's inception, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In FY 2017, nearly 86 percent of hospitals in the highest quartile of disproportionate patient percentage (DPP) received a penalty, compared to 60 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available data on socioeconomic status, such as Medicare claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. If H.R. 1343/S. 688 is passed, CMS would be required to use these data to adjust penalties, providing important relief.

The AHA also urges CMS to exclude from the HRRP readmissions unrelated to the initial reason for admission. Despite the fact that the ACA requires CMS to exclude unrelated readmissions, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

Improving the HACRP. America's hospitals are deeply committed to reducing preventable patient harm. **However, the HACRP is poorly designed and imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for the sickest patients.** The AHA will work with CMS, Congress and others to improve existing policy and promote alternatives to the HAC program that more effectively promote patient safety.

The HACRP has several critical flaws. First, the program's arbitrary design penalizes 25 percent of all hospitals each year, regardless of significant performance improvement, and it does not measure meaningful differences in quality. Indeed, the difference in HAC scores for penalized and non-penalized hospitals in FY 2015 is hundredths of a point. Second, data show that hospitals treating complex patients are disproportionally penalized, in part because the HACRP uses claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details of a patient's risk factors and course of care. We have urged CMS to remove PSIs gradually from the HACRP. Third, some small hospitals have too few patients to have data on the two infection measures used in this program. These hospitals are assessed only on the unreliable PSIs. Finally, the HAC measures overlap with the measures in the VBP Program, yet each program uses different performance periods. This can lead to excessive payment penalties and confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that the Administration use measures in either the VBP or the HAC program, but not in both.

MOVING PAY-FOR-PERFORMANCE INTO POST-ACUTE CARE

Given the widespread use of pay-for-performance in Medicare for hospitals and physicians, policymakers have begun to express an interest in adopting pay-for-performance programs for post-acute care providers. Last year, the House introduced, H.R. 3298, the Medicare Post-Acute

Care Value-Based Purchasing (PAC VBP) Act of 2015, which would repeal the FY 2018 market-basket update cap for post-acute care providers mandated by the Medicare Access and CHIP Reauthorization of 2015, and replace it with a PAC VBP program. **In concept, the AHA agrees with the potential for pay-for-performance to accelerate improvements in post-acute care. However, we urge a number of improvements to H.R. 3298, as we are concerned that the bill too narrowly focuses on reducing provider payment rather than promoting "value" – that is, the delivery of consistently high-quality care at a lower cost.**

The AHA urges Congress to reconsider the non-budget neutral design of H.R. 3298. The PAC VBP program would withhold a percentage of post-acute care provider payments. Individual providers could earn back some or all of the withheld funds – and potentially earn a bonus – based on their performance. However, the program is not budget neutral – only 50 to 70 percent of the withheld funds could be paid back to providers, with the rest being retained by Medicare as savings. The AHA does not support utilizing VBP to achieve reductions in the Medicare program; the PAC VBP program should be budget neutral.

Moreover, we urge that any PAC VBP effort use a combination of cost and quality measures, rather than focusing on cost alone. AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. The AHA believes pay-for-performance programs should include both cost *and* quality measures to ensure that the reward system encourages both high-quality care and lower costs. Those measures should be broader than just Medicare spending per beneficiary (MSPB) and a single quality measure (functional status); additional quality metrics should be included. Without a more balanced, budget-neutral approach that includes an assessment of quality, the PAC VBP program appears to function as a mechanism to cut provider payments in perpetuity, rather than primarily as a way to promote value.

Furthermore, the proposed PAC VBP scoring methodology would tie too much of an individual provider's performance to the actions of other providers that are beyond their control. The intent of the scoring methodology appears to be to encourage collaboration among providers. However, we believe there are more appropriate and effective ways to encourage collaboration, such as assessing costs during an episode of care or setting performance benchmarks for individual providers that partially reflect a geographic area. In addition, we note that any measures used in PAC VBP should be assessed for the impact of socioeconomic factors on performance; socioeconomic adjustment should be employed when needed.

Lastly, the AHA believes the PAC VBP's payment withhold should be in step with those of other Medicare VBP programs. Indeed, the hospital VBP program, the End-Stage Renal Disease Quality Improvement Program, and skilled-nursing facility VBP program all have maximum withholds of no more than 2.0 percent. Furthermore, post-acute care providers already face numerous regulatory and statutory payment reductions and restrictions in recent years – such as site-neutral payment for long-term care hospitals, the "60 percent rule" for inpatient rehabilitation facilities, and re-basing cuts for home health agencies, to name a few. Post-acute care providers also have 2.0 percent of their payments at risk for meeting extensive quality measure reporting requirements. The cumulative impact of these policies is making it significantly more challenging for these providers to serve their patients and communities.

CONCLUSION

Despite the significant challenges with existing quality measurement and pay-for-performance programs, hospitals are making important progress in improving care, as discussed in the AHA brief, "Zeroing in on the Triple Aim." By streamlining and focusing on "measures that matter," enhancing the fairness of pay-for-performance and aligning improvement across the care continuum, we believe our nation can greatly accelerate improvements in outcomes and health.

AHCA® AMERICAN HEALTH CARE ASSOCIATION
NCAL® NATIONAL CENTER FOR ASSISTED LIVING

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahcancal.org

TESTIMONY FOR THE RECORD
U.S HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS & MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON THE EVOLUTION OF QUALITY IN MEDICARE PART A
SEPTEMBER 7, 2016

The American Health Care Association (AHCA) respectfully submits the following testimony to the Members of the House Committee on Ways & Means Subcommittee on Health in regard to the hearing on *The Evolution of Quality in Medicare Part A* on September 7, 2016. With more than 12,000 skilled nursing center members, AHCA is committed to improving lives by delivering solutions for quality care.

To that end, the Association and its members have a long track record in improving care quality and advancing value-based payment systems. AHCA stands ready to work with the Congress on strategies to improve post-acute care (PAC) payment systems which will improve the quality of care for patients, produce Medicare programmatic efficiencies, and support a dynamic and innovative PAC sector.

AHCA was a strong supporter of the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014* (P.L. 113-185) because it lays the foundation for future development of value-based purchasing through the development and testing of quality reporting program (QRP) measures. AHCA believes the development of any value-based purchasing programs would benefit from the information gathered from the full implementation of the Skilled Nursing Facility Hospital Readmission Reduction Program as part of the *Protecting Access to Medicare Act of 2014* (P.L. 113–93) SNF value-based purchasing program and the IMPACT Act QRP measures. Such experience is needed before the addition of more value-based purchasing programs.

AHCA/NCAL has expressed significant concern with CMS' approach to IMPACT Act QRP development and finalization. Key areas of concern include (but not limited to): 1) lifting measures from acute care settings and applying them to PAC settings with little to no tailoring to accommodate fundamental differences between restorative and curative health care; 2) little to no notification of opportunities to comment upon measures and related specifications; and 3) technical expert panels (TEPs) which offer little opportunity for meaningful stakeholder input. In fact, due to these challenges, a group of a dozen organizations, including AHCA/NCAL, have formed an IMPACT Act Coalition aimed at attempting to better focus CMS' efforts and ensure the QRPs are appropriate for their intended use. Due to these notable challenges, AHCA/NCAL believes time is needed to gain experience with the IMPACT Act QRP measures before further value-based purchasing is added.

Additionally, AHCA has developed a SNF payment reform proposal. The AHCA SNF payment reform concept would provide greatly improved detail on the payment system

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

performance. The AHCA proposal also will generate new information which will be critical to risk adjusting outcome measures, and is, therefore, consistent with building a value based payment program that will be more accurate and precise in allocating penalties and rewards in future years (emphasis added).

Once experience is gained with the IMPACT Act QRP program, given AHCA members' experiences with AHCA's own Quality Initiative and the PAMA statutory hospital readmissions reduction program, the Association firmly believes that any PAC VBP program must be designed with the following principles as its foundation:

1. The IMPACT should be fully implemented and experience with the IMPACT Act QRP is needed before development of any additional VBP;

2. A PAC VBP program must be budget neutral across PAC payment systems and settings;

3. The amount of SNF PPS reimbursements earmarked for the VBP incentive payment pool must not exceed 2 percent of total SNF PPS payments;

4. Any PAC VBP program must be based on focused and meaningful quality outcomes measures, not just resource use, and comparisons should only be made between SNFs versus other SNFs; and

5. If a resource use measure is to be used, it should only be applied to SNF versus SNF comparisons, after making necessary adjustments for geographic differences in overhead costs.

AHCA is Leading the Way in Quality Improvement Innovations and Advancements

The Association has been – and will continue to be – an engaged partner, working with policymakers to develop new, beneficiary-first payment models. In 2011, AHCA brought to the Ways and Means Committee a legislative proposal to reduce preventable hospital readmissions for SNF patients. The Association and its members committed to reducing Medicare spending by $2 billion (from 2015 through 2024) to this effort and diligently worked with the Committee members and its staff to finalize this proposal. As a result, in 2014, Congress passed the Skilled Nursing Facility Hospital Readmission Reduction Program as part of the *Protecting Access to Medicare Act of 2014* (P.L. 113–93). This innovative, industry-backed initiative will improve quality of patient care by encouraging nursing facilities to better coordinate care with hospitals, physicians, and other PAC providers and will save the Medicare program billions of dollars.

In early 2012, AHCA launched a bold, three-year national effort to further improve the quality of care in America's skilled nursing care centers through its Quality Initiative.

The profession's ongoing efforts have improved the lives of the individuals AHCA members serve while also reducing health care costs. In 2015, the Association expanded its Quality Initiative to include measurable targets in eight key areas with a focus on three key priorities: improvements in organizational success, short-stay/post-acute care, and long-term/dementia care. The program seeks to achieve organization success by improving staff stability, increasing customer satisfaction, and reducing the number of unintended health care outcomes. It also seeks to improve short-stay/post-acute care by safely reducing hospital readmissions, increase discharge to community rates, and adopting functional measures. Lastly, the Quality Initiative aims to improve long-term and dementia care by safely reduce the off-label use of antipsychotic medication and reducing hospitalizations. The effort also includes a formalized structured process outlined by the Baldrige Performance Excellence Framework—an integrated management system intended to drive quality. This formalized system aligns with the CMS Quality Assurance/Performance Improvement program and supports the agency's national priorities such as Five-Star.

Data shows the Quality Initiative has been successful in improving care for skilled nursing residents. Since 2012, AHCA members have successfully prevented over 70,900 individuals from returning to the hospital. Member rehospitalization rates have dropped from 19.1 percent in Q4 2011 to 17.5 percent in Q4 2015. Moreover, one-in-five AHCA members have reduced readmissions by at least 30 percent. AHCA members' average use of antipsychotic medication has dropped from 23.6 percent in Q4 2011 to 16.5 percent in Q1 2016. More than half of AHCA members have achieved the initial goal of a 30 percent reduction in use of these medications as of Q1 2016. AHCA does more than just talk about the need for quality improvement – AHCA and its members proactively address it head on.

PAC VBP Must Be Budget Neutral Across PAC Payment Systems and Settings
If a pool of PAC reimbursements is set aside for VBP incentive payments, every dollar should be reinvested and redistributed back to PAC providers. The Hospital VBP program is designed in the same budget neutral manner. Therefore, it is only fair that the same principal apply to PAC VBP. After all, a value-based purchasing program should be focused on rewarding value, not simply slashing reimbursements. We continue support the concept of higher quality providers being paid more than lower quality providers, but we cannot support a punitive program that removes critical reimbursement dollars from the PAC providers. Any savings related to PAC VBP should come from behavioral changes (e.g., provider improvements in care and advancements in quality) not arbitrary, harmful cuts.

A PAC VBP Incentive Pool Must not Exceed 2 Percent of SNF PPS Payments
To ensure fairness among providers, consistency across VBP programs, and a stable SNF industry, the amount of money set aside to fund a new PAC VBP program should not exceed 2 percent of SNF PPS payments. The Hospital VBP will set aside 2 percent of

total inpatient payments once it is fully implemented.[1] Similarly, the SNF Hospital Readmission Reduction Program already reserves 2 percent of SNF PPS reimbursements.

According the Medicare Payment Advisory Commission, all-payer margins for free-standing SNFs in 2014 were just 1.9 percent, on average.[2] Earmarking more than 2 percent of SNF PPS funds risks destabilizing the financial solvency of a great number of facilities. Given the growing need for SNF care as the "baby boom" generation increasingly reaches Medicare eligibility, policymakers should avoid needlessly risking access to needed skilled nursing care.

Measures Should be Meaningful, Focused

PAC VBP should incorporate focused, meaningful quality measures that are indicative of high-quality care. AHCA recommends evaluating risk-adjusted preventable hospital readmissions and at least one measure focused on patient outcomes, such as functional outcomes as part of such a program. The IMPACT Act tasked CMS to develop both measures and their standardization is currently underway. And, as we have stated, these measures should be assessed before any new value-based purchasing programs are added.

If resource use is measured (e.g., Medicare Spending Per Beneficiary (MSPB)), we strongly believe that: 1) experience is needed from the MSPB developed as part of the IMPACT Act QRP effort; 2) any MSPB value-based purchasing program should be phased-in over time; 3) SNFs should not be held accountable for spending that occurs outside of the SNF (e.g., during the acute hospital portion of the episode); and 4)MSPB is incorporated, it should not be weighted more heavily, or assigned greater importance, than any of the patient outcomes measures. Improved outcomes for patients always (emphasis added) should be the primarily goal of value-based purchasing. Finally, AHCA recommends that if MSPB is used, it should not represent more than 10 percent of a facility's VBP score. PAC providers should be rewarded and/or penalized based on their patient outcomes, not for stinting on needed care.

PAC VBP Must Account for Geographic Differences in Overhead Costs

One proposal to establish a PAC VBP program in Medicare calls for comparing resource use between regions or service areas. Under this concept, Medicare spending that occurs in an area where long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRFs), SNFs, and home health agencies (HHAs) would be compared to spending in another service area that might just have SNFs and HHAs. Given that LTCHs and IRFs are more highly reimbursed by Medicare than SNFs and HHAs, SNFs that serve patients in these areas where LTCHs and IRFs are present would be unfairly penalized simply because of provider mix. This means that a high-quality, low-cost SNF could be paid less than a low-quality, high-cost SNF in another area simply because the higher-quality SNF was located in an area with LTCHs and IRFs. This construct would appear to run counter to the goals of VBP and is inconsistent with every other VBP program in

---

[1] In FY13, the withhold amount was 1 percent and grew 0.25 percent each year until it is fully phased in during FY17.

[2] MedPAC, Report to the Congress: Medicare Payment Policy, March 2016, page 195.

Medicare. If a resource use measure is to be used, it should only be applied to SNF versus SNF, and only after making necessary adjustments for geographic differences in overhead costs.

Additionally, the Institutes of Medicine (IOM) recommended that Congress **not adopt a geographically based value index** for Medicare payments. In its report, the IOM noted that the majority of health care decisions were made at the provider or health care organization and not by geographic regions, such that "[payments] that target (providers) are more likely than those targeting geographic regions to trigger behavioral change." IOM also noted that geographically adjusted payments "based on aggregate or composite measures of spending or quality would unfairly reward low-value providers in high-value regions and punish high-value providers in low value regions."[3] In addition to the IOM research, AHCA has conducted a review of literature on geographic variation in Medicare spending. The Association would be pleased to share this material with the Committee.

The IMPACT Act is the Cornerstone of Any PAC VBP Program

As discussed above, the IMPACT Act requires CMS to develop and implement quality measures pertaining to: functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls; and transfer of a patient's health care information and care preferences. The IMPACT Act also seeks to create measures evaluating resource use, discharge to community, and all-condition risk-adjusted potentially preventable hospital readmission rates. Many of these measures are currently under development and PAC providers are not expected to report on such measures until FY19 at the earliest. It would be premature to devise a PAC VBP program, which is so highly dependant on these measures, without first having the IMPACT Act measures finalized and integrated into the care continuum. These measures and the data derived therein are the necessary building blocks for any meaningful VBP program.

Conclusion

AHCA members have made significant investments in both resources and time to improve the quality care in SNFs across the country – and it shows. The Association's proactive posture is reflected in our Quality Initiative and the SNF VBP Program targeting rehospitalizations. AHCA remains committed to working with Congress to develop fair and meaningful SNF VBP policies that encourage improved care quality for Medicare beneficiaries while ensuring continued access to care.

Finally, the Association has developed a SNF payment reform proposal. The membership designed this proposal with four goals: 1) improve service quality and outcomes for patients; 2) provide savings to the Federal government; 3) frame an

---

[3] Institute of Medicine (IOM). (2013). Variation in Health Care Spending: Target Decision Making, Not Geography. Washington, DC: National Academies Press.

implementable system for CMS; and 4) offer a viable payment system for all members. Inherent within this proposal are concepts that move the skilled-nursing space toward a more value-based system, rewarding quality care and lowering costs. AHCA urges Congress and the Committee to consider this proposal as they seek to modernize post-acute care payments.

AJRR American Joint Replacement Registry
Improving Orthopaedic Care Through Data

9400 West Higgins Road, Suite 210
Rosemont, IL 60018-4975

847-292-0530 | fax 847-292-0531 |
www.ajrr.net

September 20, 2016

Chairman Patrick Tiberi
House Ways and Means Health Subcommittee
1102 Longworth HOB
Washington, DC 20515

Ranking Member James McDermott
House Ways and Means Health Subcommittee
1102 Longworth HOB
Washington, DC 20515

waysandmeans.submissions@mail.house.gov
(*electronic submission)*

Subject: Hearing on Incentivizing Quality Outcomes in Medicare Part A

Dear Chairman Patrick Tiberi and Ranking Member James McDermott:

The American Joint Replacement Registry (AJRR) commends the House Ways and Means Health Subcommittee for holding the Hearing on Incentivizing Quality Outcomes in Medicare Part A on September 7, 2016 to examine whether existing Medicare Part A policies are improving the quality and cost-efficiency of care in hospitals. We share the common goal of exploring ways to better improve the quality of care for Medicare patients and this is very important to the Registry community.

AJRR is the only national hip and knee arthroplasty Registry collecting data in all 50 states, and is the largest orthopaedic Registry with over 500,000 procedures, 810 hospitals, and 5,500 surgeons. AJRR collects Level I (patient, hospital, surgeon, and procedure info), some Level II (patient risk factors, comorbidities, post-operative complications, and surgical approaches) data on patients, surgeons, medical devices, and revision complications reported under the procedural codes for primary hip and knee arthroplasty, and Level III (patient-reported outcome measures). AJRR also has a mechanism in place for orthopaedic professionals to submit their Physician Quality Reporting System (PQRS) data to CMS through our Qualified Clinical Data Registry (QCDR). AJRR was designated a QCDR in FY 2014, 2015, and FY 2016.

While the hearing did not directly address registries, AJRR is submitting this letter for the record highlighting this important issue. Registries play a unique and prominent role in

improving the quality and cost-efficiency of care in hospitals and should be included as a very important topic of discussion. Registries provide detailed information about patients and procedures not routinely collected by electronic health records (EHR), administrative, or claims data. They allow for benchmarking of one provider to another, linking measurement to performance improvement and leading to the betterment of overall quality of care.

The AJRR appreciates this opportunity to provide comments to the Ways and Means Committee regarding the Hearing on Incentivizing Quality Outcomes in Medicare Part A and registries. We look forward to continuing to work with CMS to provide guidance and input on issues related to the clinical data registries. If you have questions regarding our comments, please do not hesitate to contact our Executive Director, Jeffrey P. Knezovich, CAE at (847) 292-0530 or at knezovich@ajrr.net.

Sincerely,

Daniel J. Berry, MD
Chair, American Joint Replacement Registry

cc: Jeffrey P. Knezovich, CAE, Executive Director
David G. Lewallen, MD, Medical Director

September 21, 2016 via electronic submission: waysandmeans.submissions@mail.house.gov

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

The Honorable Jim McDermott
Ranking Member
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1106 Longworth House Office Building
Washington, D.C. 20515

The Honorable Pat Tiberi
Chairman
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Ron Kind
Member of Congress
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1502 Longworth House Office Building
Washington, D.C. 20515

RE: ALMOST FAMILY SUGGESTED CHANGES TO H.R. 3298, *MEDICARE PAC-VBP ACT OF 2015*

Chairmen Brady and Tiberi, Ranking Member McDermott and Representative Kind:

Thank you for the opportunity to provide feedback on the Chairman's amendment in the nature of a substitute to H.R. 3298, *Medicare Post-Acute Value-Based Purchasing (PAC-VBP) Act of 2015*.

Almost Family, Inc., as one the nation's largest home health providers and ACO managers, has been a consistent supporter of value-based purchasing (VBP) for several years. We were honored to have been invited by the Ways and Means Health Subcommittee to testify at its September 7 hearing on "The Evolution of Quality in Medicare Part A". At the hearing, our company President Steve Guenthner said:

> "Value-based purchasing is the natural next step in the evolution of patient-centric Medicare policy, especially when it rewards providers for patient-focused outcomes, balanced against the cost incurred to achieve those outcomes… We need to change the policy question from 'how should we pay providers' to 'how we should care for patients.'"

In support of our testimony we submitted a policy paper that detailed our positions not only on VBP, but other patient-centric reforms related to chronic care management, regulatory relief and program integrity. The suggested changes to H.R. 3298 below build on this policy paper and advance our shared goal of putting patients ahead of providers across the entire Medicare Program.

Suggested Changes to H.R. 3298

We suggest the following changes to the Chairman's amendment in the nature of a substitute to H.R. 3298:

1. Page 3, Line 1-23: Restore the Market Basket Increase bargained for originally.

2. Page 6, Lines 1-2: Insert text after (ii) such that the functional status measures begin in 2020, as opposed to 2021. Indicate functional status measures shall include: (I) hospitalization; (II) emergent care without hospitalization; (III) restoring previous level of functionality and that functional status measures in a subset include five activities of daily living (e.g., ambulation, bathing, dressing, toileting and medication administration).

3. Page 12, Line 9: Insert reductions in payment basis for PAC providers beginning at the rate of 2.5% in 2020 and then by an additional 0.5% each year after 2020, such that a total reduction of 5% is reached in 2026.

4. Page 17: Insert a new section to direct the Secretary to suspend indefinitely CMMI's Pre-Claim Review (PCR) demo. Instead of spending $300 million to pilot PCR in five states,[1] we recommend Congress suspend PCR until CMS takes the following actions: (a) implement a check-the-box documentation standard for the home health face-to-face (F2F) requirement; (b) allow passage of time for providers to fully implement the new F2F regulation (we would propose 3-4 years); (c) report back to Congress on the Comprehensive Error Rate Testing process during no earlier than the third fiscal year following implementation of the regulation, with enough detail to advise Congress whether the Agency would recommend more fixes to F2F; and (d) prior to the issuance of its report to Congress, CMS should elicit feedback from stakeholders to address the administrative burden and effect on patient access to care.

5. Page 17: Create a new section directing the Secretary to use funds realized in savings from suspension of PCR to establish a demo project to determine beneficiary and family caregiver views on and goals related to the quality of care they desire in post-acute settings.

6. Page 17: Add a new section to include proposed language of Price-Walden bill on F2F simplification (name of patient, name of doctor, signature of doctor on medical necessity and date of attestation) and settlement of outstanding claims denied under F2F at 90% of claims denied and pending solely under F2F requirements for the designated time period.

7. Page 17: Add a new section that would give providers the ability to request in writing reconsideration of rankings affecting incentives under value-based purchasing policies.

[1] Centers for Medicare & Medicaid Services (CMS), "Supporting Statement Part A: Pre-Claim Review Demonstration for Home Health Services." CMS-10599/0938. July 1, 2016, page 6. Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599.html.

We appreciate this opportunity to share our feedback and look forward to continuing to work with you and your staff. We would welcome the opportunity to participate in further stakeholder discussions of these and other policy options to improve the proposed bill. If you have any questions, please do not hesitate to contact us by phone at 502-891-1000 or by email at WBY@AlmostFamily.com or SteveGuenthner@AlmostFamily.com.

Sincerely,

William B. Yarmuth
Chairman and CEO
Almost Family, Inc.

C. Steven Guenthner
President
Almost Family, Inc.

American Medical Rehabilitation Providers Association

Bruce M. Gans, MD · Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical Corporation

September 20, 2016

The Honorable Kevin Brady, Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

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

The Honorable Sander M. Levin, Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1139E Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott, Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairmen Brady and Tiberi and Ranking Members Levin and McDermott:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we welcome the opportunity to submit to the Committee on Ways and Means this statement as part of the written record of the hearing on the Evolution of Quality in Medicare Part A on September 7, 2016. In particular, we wish to provide you and your staff with our feedback on the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015, as proposed to be amended (H.R. 3298).

AMRPA commends the Committee leaders and bill sponsors for your leadership in efforts to modernize the Medicare program, including the payment systems and other policies pertaining to the post-acute care sector. We also appreciate your willingness, and that of your staffs, to work with the provider community through an iterative process to develop legislation that meaningfully achieves the shared goal of aligning Medicare payment policies with high-value care for Medicare beneficiaries.

AMRPA is the national voluntary trade association representing more than 500 members that provide rehabilitation services across the spectrum of health care settings including inpatient rehabilitation hospitals and units (IRFs), hospital outpatient departments (HOPDs), and settings independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs),

1710 N Street N.W., Washington, D.C. 20036 · Phone: 202-223-1920 · Toll-Free: 888-346-4624 · Fax: 202-223-1925
Administrative Offices: 206 South Sixth Street, Springfield, Illinois 62701 · Phone: 217-753-1190 · Fax: 217-525-1271

rehabilitation agencies, and skilled nursing facilities (SNFs). The majority of our members are Medicare participating providers, serving over 370,000 Medicare beneficiaries per year. AMRPA members help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. We appreciate the opportunity to comment on the proposed rule.

AMRPA shares your enthusiasm for redesigning Medicare payment systems to be more accountable to patients in delivering high-quality and high-value care. We believe that full implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, as well as voluntary participation in several alternative payment models (APMs), can provide a blueprint for transformative payment reforms that put patients at the center of care.

Given our long-term commitment to value-based, patient-centric reforms, we are unable to support your legislation at this time. While the current version of the PAC VBP Act represents an improvement over the introduced bill, the legislative approach of the bill presents a number of fundamental flaws and problems in design and potential execution. We look forward to working with you, other Members of Congress, and other stakeholders in developing a consensus approach to value-based payment reforms for post-acute care.

AMRPA ascribes to certain objective principles that we believe must be at the center of any VBP program. As currently constructed, the legislation is misaligned with several of these core principles. They include:

- Taking a holistic approach to measuring quality, with an emphasis on function;
- Building payment reforms upon a solid base of evidence and logically sequencing evidence development;
- Prioritizing value to patients over pure cost-containment;
- Granting providers regulatory flexibility and other tools to drive value in care delivery; and
- Counterbalancing financial incentives to stint on care with quality measurement that captures short- and longer-term outcomes.

Focusing on Value

First, any VBP program must prioritize *value* to the patient, and not solely to the Trust Fund. Determining the value of care to the patients who receive it is not a function of cost alone, but must also take into account the quality of care delivered and long-term health outcomes achieved. We struggle to see how any VBP program could prioritize value to the patient if the primary measure on which providers are judged is Medicare Spending per Beneficiary (MSPB). While resource use may be one important dimension of the value proposition, it does nothing to account for quality or health outcomes. This fact is compounded with the inherent flaws in the MSPB framework, as previously relayed by AMRPA and other stakeholders, and as confirmed by the experience of acute care providers with this measure.

Post-acute providers have little to no control over the care Medicare beneficiaries receive prior to their admission to the post-acute care setting. These “upstream” costs, primarily accruing in the acute inpatient setting, often constitute the vast majority of Medicare expenditures during

an episode of care. By comparison, acute care hospitals have flexibility to move patients to observation status or discharge them to other settings, such as post-acute care. These opportunities to control cost are significant in the context of VBP, and there are no parallels for IRFs and many other post-acute providers. We are not aware of any evidence to support the premise that MSPB is a meaningful indicator of post-acute care providers' resource use, and certainly not the quality of care they provide.

In addition, emerging evidence calls into question the validity of using MSPB measures as part of quality improvement. For example, a prominent study by researchers at the University of Minnesota revealed that use of the MSPB measure in the acute care hospitals' VBP program is disproportionately rewarding low-quality providers with bonus payments, even though it is only one of 17 measures in the program.[1] While this finding is unsurprising on one level, it is wholly unacceptable to us that a program designed to promote value can reward providers delivering suboptimal care to their patients. It would be unreasonable to expect a different result in the post-acute sector if the VBP program is based primarily on MSPB, a measure that has not yet been adopted for use in the sector. Therefore, AMRPA cannot support any VBP program that relies too heavily, or exclusively, on resource use measures for any period of time.

To truly realize more efficient resource use, providers must be given tools to effect change in the trajectory of care. This requires greater regulatory flexibility and innovations beyond the existing payment structures. As one such innovation, we urge the Committee to consider the Continuing Care Hospital (CCH) model, which the Secretary is directed by law to implement but has declined to do so.[2] The CCH model allows providers to seamlessly coordinate care across provider types and move patients through an individualized recovery process without the disruptions of conventional care transitions. If this model were fully realized, we expect it would do far more to contain costs and improve quality than withholding a portion of Medicare payment based on MSPB scores.

Measuring Quality

If the PAC VBP Act is designed to be budget neutral, then only metrics that truly capture quality will actually advance the objective of increasing the value of care. AMRPA believes the crux of delivering high-quality care entails minimizing medical errors, realizing gains in health status, achieving greater improvements in function, sustaining these improvements over longer periods of time, and ensuring patients and their caregivers are satisfied with the care received. Therefore, it is imperative that the program include a robust set of measures shown to accurately capture each of these dimensions of care.

In post-acute care, no quality domain may be more effective than function. To us, this includes measuring patients' gains in cognitive and physical function and is a fundamental measure of the total impact of rehabilitation. Patients' achievement of meaningful gains in activities of daily living (ADL), for example, is not only a major reason to invest in their rehabilitation in the first place, but is highly indicative of their long-term health and wellbeing. Individuals with

---

[1] Anup Das et al., *Adding a Spending Metric to Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals*, 35 HEALTH AFFAIRS 898, 904 (May 2016).

[2] 42 U.S.C. § 1395cc-4(g).

higher function are more capable of caring for themselves, more likely to remain in the community, and better equipped to return to work or an active retirement. For these reasons, we applaud the Committee for incorporating function into the PAC VBP's proposed measure set. And, for these same reasons, AMRPA feels strongly that a VBP program must not begin until there are standardized measures of function that have been validated and accepted across all sites of service.

The subsequent addition of one additional measure domain several years into the VBP program is wholly inadequate, from AMRPA's perspective. For one thing, there is no requirement that the measure of function be an outcome measure. At present, the only cross-setting measure CMS has adopted under the IMPACT Act is a process measure assessing only how many patients had a plan of care that addresses function. This appears to be a major reason that MedPAC has voiced concern with the adoption of this measure.[3]

Despite the utmost importance of functional outcomes, they are by no means the exclusive measure of the quality of post-acute care. Other domains, such as return to community, are fundamental to the long-term health of patients and must be part of any program purporting to evaluate providers for the value of care they deliver. MSPB measures have been shown to incentivize stinting on medically necessary care.[4] Given these incentives, a VBP measure set consisting solely of MSPB could create a race to the bottom and thus it is important that quality measures that meaningfully capture the short- and long-term effects of medical decision-making be brought online in tandem with resource use measures. The more dimensions of quality included in the programmatic measure set, the more comprehensive the value assessment can be, and the less likely the program is to repeat the pitfalls of prior initiatives that are rewarding low-quality outcomes. It is therefore important that resource use measures comprise a significantly smaller proportion of the composite score than domains more fundamental to quality and long-term patient outcomes.

Building on the Evidence

AMRPA believes Congress must permit the IMPACT Act to be fully implemented before layering additional post-acute payment reforms on top of it. Imposing a VBP program now is premature. Full implementation of the IMPACT Act will allow the cross-setting lessons of the IMPACT Act to inform cross-setting programs like PAC VBP. As Chairman Brady previously explained, "The IMPACT Act lays the foundation for future reform. The Act establishes standard data and metrics . . . [that] will allow Congress to make future reforms armed with the facts."[5] Until the IMPACT Act's standardized assessment tools and quality measures are in use, and shown to be collecting valid and meaningful data, it would be imprudent for Congress to lock them into other programs by statutory reference.

In addition, the data analyses required by the IMPACT Act may set the stage for future changes to practices in post-acute care. In fact, patients could end up being cared for quite differently and in different settings than they are today, which is another reason why locking

[3] Carol Carter, Uniform Outcome Measures under a Unified Post-Acute Care Payment System (MedPAC, Sept. 8, 2016).
[4] Das et al., *supra* note 1.
[5] Statement of Mr. Brady on H.R. 4994, 160 CONG. REC. H7610 (daily ed. Sept. 16, 2014).

the program into statute today is ill-advised. Instead, AMRPA encourages the Committee to facilitate complete implementation of the IMPACT Act in accordance with the law's specified timeline.

Moderating Financial Incentives
The magnitude of payment withholds under a PAC VBP program must be appropriate and fair, and proportional to analogous programs. AMRPA believes that the PAC VBP Act, both as proposed and as amended, fails to meet these standards. While the previously proposed maximum withhold of 8 percent is excessive relative to every other VBP program with which we are familiar, the immediate 5 percent withhold in the revised bill is equally incongruous and potentially unfair. Steep downside-only risk has not been demonstrated to be an effective driver of quality and, conversely, more moderate financial risk has shown to be effective in changing provider behavior. We further believe that a 5 percent withhold with no phase-in period would be an unreasonable starting point for a sector in which Medicare payments have not previously been tied to performance. These concerns are amplified further in a program that consists of only a single performance domain (*i.e.*, resource use) in the preliminary years of the program, as proposed.

Instead, AMRPA supports a phased-in approach to payment consequences consistent with prior value-based payment programs. Specifically, the payment withhold should mirror the Hospital VBP program, which began with a 1.0 percent withhold and increased to 2.0 percent over five years. Efforts to equate the PAC VBP Act's withhold with the entirety of double-sided payment consequences for acute care hospitals are inapt. For one thing, VBP is a single program based on a small measure set (and a single resource use measure initially) and should not carry the same risk that acute care hospitals distribute across numerous programs, some of which pose very low risk for payment reduction. In addition, as hospitals, IRFs and long-term acute care hospitals (LTCHs) already face certain payment reductions and penalties applicable to acute care hospitals.

For example, IRFs are also subject to payment penalties for failing to report quality measures to CMS and several payment reductions pursuant to the Affordable Care Act which is included within the 8 percent figure used to compare the Hospital VBP program with the proposed PAC VBP program. Finally, the majority of IRFs are units within larger hospitals subject to these payment risks and other hospital cuts imposed by the Affordable Care Act. Thus, IRFs and certain other post-acute providers would be subject to a "double hit" if the PAC VBP program were calibrated to match the entirety of payment risk borne by inpatient acute care hospitals. AMRPA could not support legislation that creates greater risk for post-acute providers than for other VBP programs.

Finally, AMRPA urges the Committee to reinvest any savings generated by the proposed PAC VBP withhold mechanism back into the IRF prospective payment system (PPS) and other payment systems *proportionally*. This approach is consistent with the Hospital VBP program and it is imperative that the integrity of each impacted payment system be preserved. As noted, quality-based reforms that feature double-sided risk are more likely to improve provider performance whereas downside-only risk is not constructive and, in this case, punitive.

Regulatory Relief
AMRPA is a major proponent of the broad concept of "regulatory relief." We greatly appreciate the Committee's recognition that various Medicare policies add enormous complexity, burdens, and costs to the system—and ultimately taxpayers—without offering meaningful safeguards for patients or the program. As hospitals, IRFs are subject to numerous such regulations that are generally applicable as well as many additional requirements unique to IRFs' exclusion from the Hospital Inpatient PPS. We welcome the opportunity to work with the Committee and discuss ways to improve this complex and burdensome regulatory framework with the Committee in greater detail.

However, we do not believe regulatory relief should be intertwined with this legislation. Relief from existing regulatory burdens is not something that we believe is appropriate to exchange for new regulatory programs that impose steep payment cuts and would add substantial additional burdens on taxed providers. We do not believe it is practical to prospectively value the costs of modernizing various outmoded requirements. Furthermore, our members are concerned that the Congressional Budget Office's (CBO) estimate of what regulatory relief would cost the government may not necessarily correspond to dollar-for-dollar relief to individual providers.

Again, we propose that the PAC VBP program be required to reinvest any withheld payments back into Medicare payments directly, which is the only sound way to ensure the program is budget neutral and does not cost-shift from one post-acute care sector to another. Separately, we urge the Committee to continue to consider regulatory relief in the context of much needed reforms to the program, including holding stakeholder listening sessions, subject matter hearings, and legislative hearings on pending reform proposals.

* * *

AMRPA is part of the ad hoc coalition of post-acute care stakeholders that submitted a joint letter to the authors of the PAC VBP Act (H.R. 3298) on September 15. AMRPA associates itself with all of the comments and concerns raised in that letter.

While we look forward to working with you and your staff on VBP reforms and other important issues, we oppose the PAC VBP Act in its current form. However, we would like to reiterate our appreciation for your willingness to work with interested stakeholders and are optimistic we can work towards a consensus policy.

Sincerely,

Bruce M. Gans, MD
Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

cc: Members of the House Committee on Ways and Means

American Medical Rehabilitation Providers Association

Bruce M. Gans, MD · Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical Corporation

September 20, 2016

The Honorable Kevin Brady, Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

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

The Honorable Sander M. Levin, Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1139E Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott, Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairmen Brady and Tiberi and Ranking Members Levin and McDermott:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we welcome the opportunity to submit to the Committee on Ways and Means this statement as part of the written record of the hearing on the Evolution of Quality in Medicare Part A on September 7, 2016. In particular, we wish to provide you and your staff with our feedback on the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015, as proposed to be amended (H.R. 3298).

AMRPA commends the Committee leaders and bill sponsors for your leadership in efforts to modernize the Medicare program, including the payment systems and other policies pertaining to the post-acute care sector. We also appreciate your willingness, and that of your staffs, to work with the provider community through an iterative process to develop legislation that meaningfully achieves the shared goal of aligning Medicare payment policies with high-value care for Medicare beneficiaries.

AMRPA is the national voluntary trade association representing more than 500 members that provide rehabilitation services across the spectrum of health care settings including inpatient rehabilitation hospitals and units (IRFs), hospital outpatient departments (HOPDs), and settings independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs),

1710 N Street N.W., Washington, D.C. 20036 · Phone: 202-223-1920 · Toll-Free: 888-346-4624 · Fax: 202-223-1925
Administrative Offices: 206 South Sixth Street, Springfield, Illinois 62701 · Phone: 217-753-1190 · Fax: 217-525-1271

rehabilitation agencies, and skilled nursing facilities (SNFs). The majority of our members are Medicare participating providers, serving over 370,000 Medicare beneficiaries per year. AMRPA members help patients maximize their health, functional skills, independence, and participation in society so they can return to home, work, or an active retirement. We appreciate the opportunity to comment on the proposed rule.

AMRPA shares your enthusiasm for redesigning Medicare payment systems to be more accountable to patients in delivering high-quality and high-value care. We believe that full implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, as well as voluntary participation in several alternative payment models (APMs), can provide a blueprint for transformative payment reforms that put patients at the center of care.

Given our long-term commitment to value-based, patient-centric reforms, we are unable to support your legislation at this time. While the current version of the PAC VBP Act represents an improvement over the introduced bill, the legislative approach of the bill presents a number of fundamental flaws and problems in design and potential execution. We look forward to working with you, other Members of Congress, and other stakeholders in developing a consensus approach to value-based payment reforms for post-acute care.

AMRPA ascribes to certain objective principles that we believe must be at the center of any VBP program. As currently constructed, the legislation is misaligned with several of these core principles. They include:

- Taking a holistic approach to measuring quality, with an emphasis on function;
- Building payment reforms upon a solid base of evidence and logically sequencing evidence development;
- Prioritizing value to patients over pure cost-containment;
- Granting providers regulatory flexibility and other tools to drive value in care delivery; and
- Counterbalancing financial incentives to stint on care with quality measurement that captures short- and longer-term outcomes.

Focusing on Value

First, any VBP program must prioritize *value* to the patient, and not solely to the Trust Fund. Determining the value of care to the patients who receive it is not a function of cost alone, but must also take into account the quality of care delivered and long-term health outcomes achieved. We struggle to see how any VBP program could prioritize value to the patient if the primary measure on which providers are judged is Medicare Spending per Beneficiary (MSPB). While resource use may be one important dimension of the value proposition, it does nothing to account for quality or health outcomes. This fact is compounded with the inherent flaws in the MSPB framework, as previously relayed by AMRPA and other stakeholders, and as confirmed by the experience of acute care providers with this measure.

Post-acute providers have little to no control over the care Medicare beneficiaries receive prior to their admission to the post-acute care setting. These “upstream” costs, primarily accruing in the acute inpatient setting, often constitute the vast majority of Medicare expenditures during

an episode of care. By comparison, acute care hospitals have flexibility to move patients to observation status or discharge them to other settings, such as post-acute care. These opportunities to control cost are significant in the context of VBP, and there are no parallels for IRFs and many other post-acute providers. We are not aware of any evidence to support the premise that MSPB is a meaningful indicator of post-acute care providers' resource use, and certainly not the quality of care they provide.

In addition, emerging evidence calls into question the validity of using MSPB measures as part of quality improvement. For example, a prominent study by researchers at the University of Minnesota revealed that use of the MSPB measure in the acute care hospitals' VBP program is disproportionately rewarding low-quality providers with bonus payments, even though it is only one of 17 measures in the program.[1] While this finding is unsurprising on one level, it is wholly unacceptable to us that a program designed to promote value can reward providers delivering suboptimal care to their patients. It would be unreasonable to expect a different result in the post-acute sector if the VBP program is based primarily on MSPB, a measure that has not yet been adopted for use in the sector. Therefore, AMRPA cannot support any VBP program that relies too heavily, or exclusively, on resource use measures for any period of time.

To truly realize more efficient resource use, providers must be given tools to effect change in the trajectory of care. This requires greater regulatory flexibility and innovations beyond the existing payment structures. As one such innovation, we urge the Committee to consider the Continuing Care Hospital (CCH) model, which the Secretary is directed by law to implement but has declined to do so.[2] The CCH model allows providers to seamlessly coordinate care across provider types and move patients through an individualized recovery process without the disruptions of conventional care transitions. If this model were fully realized, we expect it would do far more to contain costs and improve quality than withholding a portion of Medicare payment based on MSPB scores.

Measuring Quality

If the PAC VBP Act is designed to be budget neutral, then only metrics that truly capture quality will actually advance the objective of increasing the value of care. AMRPA believes the crux of delivering high-quality care entails minimizing medical errors, realizing gains in health status, achieving greater improvements in function, sustaining these improvements over longer periods of time, and ensuring patients and their caregivers are satisfied with the care received. Therefore, it is imperative that the program include a robust set of measures shown to accurately capture each of these dimensions of care.

In post-acute care, no quality domain may be more effective than function. To us, this includes measuring patients' gains in cognitive and physical function and is a fundamental measure of the total impact of rehabilitation. Patients' achievement of meaningful gains in activities of daily living (ADL), for example, is not only a major reason to invest in their rehabilitation in the first place, but is highly indicative of their long-term health and wellbeing. Individuals with

---

[1] Anup Das et al., *Adding a Spending Metric to Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals*, 35 HEALTH AFFAIRS 898, 904 (May 2016).

[2] 42 U.S.C. § 1395cc-4(g).

higher function are more capable of caring for themselves, more likely to remain in the community, and better equipped to return to work or an active retirement. For these reasons, we applaud the Committee for incorporating function into the PAC VBP's proposed measure set. And, for these same reasons, AMRPA feels strongly that a VBP program must not begin until there are standardized measures of function that have been validated and accepted across all sites of service.

The subsequent addition of one additional measure domain several years into the VBP program is wholly inadequate, from AMRPA's perspective. For one thing, there is no requirement that the measure of function be an outcome measure. At present, the only cross-setting measure CMS has adopted under the IMPACT Act is a process measure assessing only how many patients had a plan of care that addresses function. This appears to be a major reason that MedPAC has voiced concern with the adoption of this measure.[3]

Despite the utmost importance of functional outcomes, they are by no means the exclusive measure of the quality of post-acute care. Other domains, such as return to community, are fundamental to the long-term health of patients and must be part of any program purporting to evaluate providers for the value of care they deliver. MSPB measures have been shown to incentivize stinting on medically necessary care.[4] Given these incentives, a VBP measure set consisting solely of MSPB could create a race to the bottom and thus it is important that quality measures that meaningfully capture the short- and long-term effects of medical decision-making be brought online in tandem with resource use measures. The more dimensions of quality included in the programmatic measure set, the more comprehensive the value assessment can be, and the less likely the program is to repeat the pitfalls of prior initiatives that are rewarding low-quality outcomes. It is therefore important that resource use measures comprise a significantly smaller proportion of the composite score than domains more fundamental to quality and long-term patient outcomes.

Building on the Evidence

AMRPA believes Congress must permit the IMPACT Act to be fully implemented before layering additional post-acute payment reforms on top of it. Imposing a VBP program now is premature. Full implementation of the IMPACT Act will allow the cross-setting lessons of the IMPACT Act to inform cross-setting programs like PAC VBP. As Chairman Brady previously explained, "The IMPACT Act lays the foundation for future reform. The Act establishes standard data and metrics . . . [that] will allow Congress to make future reforms armed with the facts."[5] Until the IMPACT Act's standardized assessment tools and quality measures are in use, and shown to be collecting valid and meaningful data, it would be imprudent for Congress to lock them into other programs by statutory reference.

In addition, the data analyses required by the IMPACT Act may set the stage for future changes to practices in post-acute care. In fact, patients could end up being cared for quite differently and in different settings than they are today, which is another reason why locking

[3] Carol Carter, Uniform Outcome Measures under a Unified Post-Acute Care Payment System (MedPAC, Sept. 8, 2016).
[4] Das et al., *supra* note 1.
[5] Statement of Mr. Brady on H.R. 4994, 160 CONG. REC. H7610 (daily ed. Sept. 16, 2014).

the program into statute today is ill-advised. Instead, AMRPA encourages the Committee to facilitate complete implementation of the IMPACT Act in accordance with the law's specified timeline.

Moderating Financial Incentives
The magnitude of payment withholds under a PAC VBP program must be appropriate and fair, and proportional to analogous programs. AMRPA believes that the PAC VBP Act, both as proposed and as amended, fails to meet these standards. While the previously proposed maximum withhold of 8 percent is excessive relative to every other VBP program with which we are familiar, the immediate 5 percent withhold in the revised bill is equally incongruous and potentially unfair. Steep downside-only risk has not been demonstrated to be an effective driver of quality and, conversely, more moderate financial risk has shown to be effective in changing provider behavior. We further believe that a 5 percent withhold with no phase-in period would be an unreasonable starting point for a sector in which Medicare payments have not previously been tied to performance. These concerns are amplified further in a program that consists of only a single performance domain (*i.e.*, resource use) in the preliminary years of the program, as proposed.

Instead, AMRPA supports a phased-in approach to payment consequences consistent with prior value-based payment programs. Specifically, the payment withhold should mirror the Hospital VBP program, which began with a 1.0 percent withhold and increased to 2.0 percent over five years. Efforts to equate the PAC VBP Act's withhold with the entirety of double-sided payment consequences for acute care hospitals are inapt. For one thing, VBP is a single program based on a small measure set (and a single resource use measure initially) and should not carry the same risk that acute care hospitals distribute across numerous programs, some of which pose very low risk for payment reduction. In addition, as hospitals, IRFs and long-term acute care hospitals (LTCHs) already face certain payment reductions and penalties applicable to acute care hospitals.

For example, IRFs are also subject to payment penalties for failing to report quality measures to CMS and several payment reductions pursuant to the Affordable Care Act which is included within the 8 percent figure used to compare the Hospital VBP program with the proposed PAC VBP program. Finally, the majority of IRFs are units within larger hospitals subject to these payment risks and other hospital cuts imposed by the Affordable Care Act. Thus, IRFs and certain other post-acute providers would be subject to a "double hit" if the PAC VBP program were calibrated to match the entirety of payment risk borne by inpatient acute care hospitals. AMRPA could not support legislation that creates greater risk for post-acute providers than for other VBP programs.

Finally, AMRPA urges the Committee to reinvest any savings generated by the proposed PAC VBP withhold mechanism back into the IRF prospective payment system (PPS) and other payment systems *proportionally*. This approach is consistent with the Hospital VBP program and it is imperative that the integrity of each impacted payment system be preserved. As noted, quality-based reforms that feature double-sided risk are more likely to improve provider performance whereas downside-only risk is not constructive and, in this case, punitive.

Regulatory Relief
AMRPA is a major proponent of the broad concept of "regulatory relief." We greatly appreciate the Committee's recognition that various Medicare policies add enormous complexity, burdens, and costs to the system—and ultimately taxpayers—without offering meaningful safeguards for patients or the program. As hospitals, IRFs are subject to numerous such regulations that are generally applicable as well as many additional requirements unique to IRFs' exclusion from the Hospital Inpatient PPS. We welcome the opportunity to work with the Committee and discuss ways to improve this complex and burdensome regulatory framework with the Committee in greater detail.

However, we do not believe regulatory relief should be intertwined with this legislation. Relief from existing regulatory burdens is not something that we believe is appropriate to exchange for new regulatory programs that impose steep payment cuts and would add substantial additional burdens on taxed providers. We do not believe it is practical to prospectively value the costs of modernizing various outmoded requirements. Furthermore, our members are concerned that the Congressional Budget Office's (CBO) estimate of what regulatory relief would cost the government may not necessarily correspond to dollar-for-dollar relief to individual providers.

Again, we propose that the PAC VBP program be required to reinvest any withheld payments back into Medicare payments directly, which is the only sound way to ensure the program is budget neutral and does not cost-shift from one post-acute care sector to another. Separately, we urge the Committee to continue to consider regulatory relief in the context of much needed reforms to the program, including holding stakeholder listening sessions, subject matter hearings, and legislative hearings on pending reform proposals.

* * *

AMRPA is part of the ad hoc coalition of post-acute care stakeholders that submitted a joint letter to the authors of the PAC VBP Act (H.R. 3298) on September 15. AMRPA associates itself with all of the comments and concerns raised in that letter.

While we look forward to working with you and your staff on VBP reforms and other important issues, we oppose the PAC VBP Act in its current form. However, we would like to reiterate our appreciation for your willingness to work with interested stakeholders and are optimistic we can work towards a consensus policy.

Sincerely,

Bruce M. Gans, MD
Chair, AMRPA Board of Directors
Executive Vice President and Chief Medical Officer, Kessler Institute for Rehabilitation
National Medical Director for Rehabilitation, Select Medical

cc: Members of the House Committee on Ways and Means

AOTA® The American Occupational Therapy Association, Inc.

Occupational Therapy: Living Life To Its Fullest®

September 21, 2016

SENT BY ELECTRONIC MAIL

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

The Honorable Sander M. Levin
Ranking Member
House Committee on Ways and Means
1236 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

The Honorable Jim McDermott
Ranking Member
House Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

Re: Written Statement for the Record on H.R. 3298: Medicare Post-Acute Care Value-Based Purchasing Act of 2015

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

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Many occupational therapy practitioners serve Medicare beneficiaries in post-acute care (PAC) settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs) and long term care hospitals (LTCHs). This letter is in response to a call for written statement on the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015* (H.R. 3298).

AOTA has supported improving the quality of care provided in PAC settings and has been working to be a collaborative partner with Centers for Medicare and Medicaid Services (CMS) staff to assist with implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT Act) since it significantly affects the profession of occupational therapy.

Having worked with CMS on implementation of IMPACT, AOTA is concerned that H.R. 3298 would use only a single measure, the Medicare Spending per Beneficiary (MSPB), on which to base incentive payments for PAC settings. MSPB is not a measure of quality, rather is it a measure of Medicare utilization and provider productivity. While the changes to the bill released on September 6th would reportedly include measures of function, these measures would not play a role in distribution of incentives until 2 years after implementation of the bill.

4720 Montgomery Lane 301-652-2682 800-377-8555 TDD
Bethesda, MD 20814-1220 301-652-7711 fax www.aota.org

As witnesses at the September 7 hearing noted, a redesigned Medicare PAC payment system should be tied to minimum quality thresholds, but quality should include measures of patient outcomes, not just cost. A recent article, "Higher Hospital Spending on Occupational Therapy is Associated with Lower Readmission Rates," found that higher utilization of occupational therapy services in acute care settings were associated with lower readmission rates[1]. Researchers used Medicare claims and cost data to examine the association between hospital spending for specific services and 30-day admission rates for heart failure, pneumonia, and acute myocardial infarction. They noted:

> **We found that occupational therapy is the only spending category where additional spending has a statistically significant association with lower readmission rates for all three medical conditions. One possible explanation is that occupational therapy places a unique and immediate focus on patients' functional and social needs, which can be important drivers of readmission if left unaddressed.**

This pointed conclusion should be considered when looking at service utilization in PAC as well. Occupational therapy as part of the comprehensive plan for patients in acute and in PAC settings can reap significant systemic and patient level benefits. Such benefits would not be captured by the MSPB, but could reasonably reduce overall costs to the Medicare system.

AOTA is also concerned at the lack of clarity in how provisions in the Medicare Post-Acute Care Value-Based Purchasing Act align with IMPACT Act. The IMPACT Act's purpose is to evaluate and realign the incentives and payment for inpatient and post-acute care (PAC) services provided under the Medicare program as well as to further quality service provision. IMPACT also brings attention to related issues such as resource utilization, patient safety, reducing caregiver burden and enhancing discharge planning and placement. The areas of emphasis for data and quality identified in the IMPACT ACT include medical, functional, cognitive and social supports. The Act requires attention to these constructs for purposes of predicting post-acute care resource needs, promoting continuity of care, avoiding preventable hospital readmissions and achieving positive outcomes for Medicare beneficiaries as a result of receiving Medicare PAC services. These are all key elements of providing high-quality patient-centered care that focuses on outcomes of importance to the patients themselves, and should be minimum elements of a PAC incentive payment program.

Finally, we urge the committee to think about what happens to patients when they end their post acute care. It is important to measure providers contributions, as they affect long-term success for post-discharge. Occupational therapists provide services to make patients independent and able to be discharged to the community. It is critical for occupational therapists to evaluate what a patient needs to do when an episode and care ends, as well as determine what support is available to the patient after discharge. This includes patients following through on provider instructions, exercises, and successfully navigating their home environment. Attention to these considerations allows a patient to have a successful discharge to the community. We suggest that

---

[1] Rogers, A.; Bai, G.; Lavin, R.; & Anderson, G. (2016). Higher Hospital Spending on Occupational Therapy is Associated with Lower Readmission Rates. *Medical Care Research and Review*, Advance online publication, doi: 10.1177/107755871666698

quality measures should be considered beyond an immediate episode of care, such as 60 days post-discharge, when measuring the true value of care.

* * * * *

Thank you for allowing us to comment on this important issue of value-based purchasing in post-acute care. AOTA looks forward to a continuing dialogue with the Ways and Means Committee on how to improve the quality and cost-efficiency of post-acute care.

Sincerely,

Heather Parsons
Director of Federal Affairs
American Occupational Therapy Association

American Therapeutic Recreation Association
207 Third Avenue • Hattiesburg, MS 39401 • (601) 450-2872 • www.atra-online.com

VIA ELECTRONIC MAIL

September 20, 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

RE: Statement for the Record on Value-Based Purchasing of Post-Acute Care (H.R. 3298)

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

The American Therapeutic Recreation Association (ATRA) is the national membership organization representing the interests and needs of therapeutic recreation specialists, also known as recreational therapists. Recreational therapists are healthcare providers who plan, direct, deliver, and evaluate activity-based interventions to address the medical and functional needs of individuals with illnesses and/or disabling conditions. Recreational therapy is active treatment, prescribed by a physician as part of a plan of care, and plays an important role in the comprehensive rehabilitation of individuals with illnesses and/or disabling conditions. Many of our clinicians practice in post-acute care settings.

We understand from your recently proposed "greensheet" update to H.R. 3298, the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015*, that you intend to include provisions that will provide regulatory relief to post-acute care providers. Given our members' dedicated clinical work in post-acute care settings, we are writing to offer our strong support for a regulatory relief proposal related to the bill. As post-acute care clinical providers, we would like to take this opportunity to thank the Committee for its interest in post-acute care, and express our general support for the important transition from volume-based to value-based care that is occurring in healthcare. However, as individual clinicians practicing under Medicare's prospective payment systems within post-acute care settings, we do not take a strong position on H.R. 3298.

Rather, we wish to provide the Committee with our strong endorsement of H.R. 1906, the *Access to Inpatient Rehabilitation Therapy Act of 2015*, a "regulatory relief" proposal that may be well suited to the Committee's expressed goals of reinvesting in post-acute care through such proposals.

H.R. 1906 would provide needed flexibility to the "intensity of therapy" requirement that the Centers for Medicare and Medicaid Services (CMS) uses to help determine which Medicare beneficiaries are

appropriate for treatment in an inpatient rehabilitation hospital and unit (IRF). Currently, in order to qualify for coverage in an IRF, a Medicare beneficiary with an injury, illness, disability or chronic condition must require a sufficient intensity of therapy services (i.e., at least three hours per day, 15 hours per week). Prior to 2010, CMS regulations for IRFs explicitly stated that physical therapy, occupational therapy, speech therapy and/or orthotics and prosthetics were counted toward the "intensity of therapy" requirement on an as-needed basis.

Importantly, CMS regulations also stated that "other therapeutic modalities," such as recreational therapy, that were determined by the physician and the rehabilitation team to be needed by the patient "on a priority basis" would qualify toward satisfaction of the so-called "Three Hour Rule." However, in 2010, CMS updated its IRF regulations, and removed the language that allowed other therapeutic modalities such as recreational therapy to qualify toward satisfaction of the Three Hour Rule.

As a result, many Medicare beneficiaries have lost access to recreational therapy services, as some rehabilitation hospitals and units eliminated their capacity to provide recreational therapy services, and are no longer capable of offering these services to patients who need them. This hamstrings rehabilitation physicians and their rehabilitation teams from providing the appropriate mix of therapy services specifically tailored to meet the patients' medical and functional needs in a timely and efficient manner. In addition, it potentially denies individual patients access to a Medicare benefit to which they are entitled, the costs of which have already been incorporated into the IRF prospective payment rate structure. Rehabilitation organizations have requested CMS to modify the regulations to provide greater flexibility in meeting the intensity of therapy requirement, but CMS has not done so to date.

Congressman Glenn Thompson (R-PA) and Congressman G.K. Butterfield (D-NC) have introduced the *Access to Inpatient Rehabilitation Therapy Act of 2015* (H.R. 1906) as a legislative solution to this access to care problem. The bill seeks to restore flexibility and physician judgment when determining which therapeutic services are counted toward the intensity of therapy requirement (i.e., the Three Hour Rule), including recreational therapy, thereby granting more patients access to needed care. This legislation is expected to be budget neutral and will help facilitate access to the appropriate mix of services in the IRF setting.

Most importantly, H.R. 1906 will benefit people with brain injuries, spinal cord injuries, strokes, amputations, neurological disorders, and a wide range of other conditions. As the membership organization for recreational therapists who provide this important clinical service to Medicare beneficiaries recovering from injuries and illnesses in post-acute care settings, **we respectfully request that the Committee include H.R. 1906 as one of its regulatory relief measures in its post-acute care value-based purchasing legislation at such time as the legislative begins to move through the committee.**

If you have any questions, please contact our Washington counsel, Peter Thomas, at 202-466-6550 or peter.thomas@ppsv.com. Thank you for your consideration of this statement for the record.

Sincerely,

Thomas K. Skalko, Ph.D., LRT/CTRS,FDRT
Federal Public Policy Co-Chair

September 21, 2016

SENT BY ELECTRONIC MAIL

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

The Honorable Sander M. Levin
Ranking Member
House Committee on Ways and Means
1236 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

The Honorable Jim McDermott
Ranking Member
House Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

Re: Written Statement for the Record on H.R. 3298: Medicare Post-Acute Care Value-Based Purchasing Act of 2015

Dear Chairman Brady, Chairman Tiberi, Ranking Member Levin, and Ranking Member McDermott:

The Coalition to Preserve Rehabilitation (CPR) is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function. This letter constitutes our written statement on the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015* (H.R. 3298), in connection to the September 6 Ways and Means Health Subcommittee hearing entitled "Evolution of Quality in Medicare Part A."

CPR organizations strongly support the improvement of quality in post-acute care services and have long supported the establishment of quality measures that include assessments of health, functional status, and quality of life. We believe that post-acute care value-based purchasing (PAC-VBP) legislation should focus, first and foremost, on incentivizing quality improvement and access to the appropriate amount, intensity, duration and scope of both rehabilitation services

and medical management to meet individual patient[1] needs. Above all, establishment of PAC-VBP should do no harm. Whenever financial incentives are established, it is critical to ensure that beneficiaries have appropriate access to care and are not underserved. In short, PAC-VBP legislation needs to primarily focus on the production of high quality care and the achievement of superior outcomes for Medicare beneficiaries with injuries, illnesses, disabilities, and chronic conditions that will maximize their quality of life and minimize their need for ongoing care and support.

For this reason, our comments on H.R. 3298, as amended by the set of changes to the bill released on September 6th, are targeted to the use of the Medicare Spending per Beneficiary (MSPB) measure. MSPB is the only measure contemplated under the original version of H.R. 3298, according to Ways and Means Committee correspondence to Secretary Burwell.[2] As the committee is well aware, MSPB is an economic measure to assess Medicare utilization and is used to ascertain the productivity of a provider within a given setting, or a type of provider compared to another type of provider.

MSPB does not measure the amount, duration, intensity, or scope of health care or rehabilitation services actually provided to beneficiaries, nor does it measure patient outcomes or quality of care. MSPB does not take into consideration the concept of patient severity, the level or resources that are medically indicated to meet patient needs, or the functional gains to be achieved through higher intensity, coordinated, interdisciplinary rehabilitation and post-acute care for Medicare beneficiaries with injuries, illnesses, disabilities, and chronic conditions.

The proposed changes to the legislation released September 6th indicated that, in addition to the MSPB measure taking effect in 2019, a functional measure would be added to the PAC-VBP program two years later, in 2021. We strongly support the addition of functional measures to the any PAC-VBP system. In fact, along with broader quality measures, these are the factors that should be assessed when determining whether to grant a particular PAC provider a financial reward for providing high quality care. But we believe the addition of one functional measure is wholly inadequate to assess the functional status of a wide variety of Medicare patients with different conditions and differing levels of severity across the post-acute care continuum.

The PAC-VBP program should not measure MSPB without simultaneously measuring quality, function, and quality of life outcomes so that the Medicare program knows what it is getting for its payments to providers. Further, any quality measure must take into account the success in maintaining function, or slowing decline, not just improvement. A suite of quality, function, and quality of life measures that are appropriate for assessment across PAC settings should be developed, validated, and implemented simultaneously, before any financial incentives are paid to providers. This was the theory behind the Improving Medicare Post-Acute Care

---

[1] For brevity, we refer in various places in our comments to "patient" and "care," given that payment reform is rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

[2] Letter from Chairman Brady and Rep. Kind to HHS Secretary Silvia Burwell, House Ways and Means Committee Website, July 29, 2015. Appendix A states, "H.R. 3298 proposes to use one quality measure--the Medicare Spending Per Beneficiary (MSPB) measure....Rather than dictate which aspects of care are important, H.R. 3298 sets one clear performance target and allows providers to choose for themselves what to focus on in order to achieve a singular outcome."

Transformation Act of 2014 (IMPACT Act), which is in the midst of being implemented by the Centers for Medicare and Medicaid Services (CMS). We advocate that any legislation adopt the same measures as the IMPACT ACT.

CPR, therefore, views H.R. 3298 as premature and not evidence-based. As currently contemplated, the bill is predominantly aimed at promoting efficiency of treatment and reduction in spending, not quality improvement. It has the likely potential of driving Medicare beneficiaries to less costly, less intense rehabilitation settings that may, in fact, save the Medicare program money in the near term, but at the expense of high quality care, good patient outcomes, and appropriate cost savings that minimize patients' need for ongoing care and support over the remaining years of their life. The PAC-VBP must expressly include both quality performance standards as well as expenditure benchmarks. The hospital VBP program did not include quality performance standards and focused solely on savings. As a consequence, hospitals providing low quality care nevertheless received bonus payments.[3]

We strongly urge the subcommittee to reconsider the structure of this legislation to ensure that any PAC-VBP bill that becomes law has as its foundation robust quality, function, and quality of life measures to ensure that Medicare is getting value for its provider payments while beneficiaries have access to appropriate post-acute care treatment that yields the best outcomes.

We greatly appreciate your attention to the concerns of the CPR membership, and supporting organizations, listed below. Should you have further questions regarding this information, please contact Peter Thomas and Steve Postal, CPR staff, by emailing Steve.Postal@ppsv.com and Peter.Thomas@ppsv.com or by calling 202-466-6550.

****

[3] Anup Das, Edward C. Norton, David C. Miller, Andrew M. Ryan, John D. Birkmeyer, Lena M. Chen, "Adding A Spending Metric To Medicare's Value-Based Purchasing Program Rewarded Low-Quality Hospitals," *Health Affairs* 35, No. 5 (2016): 898-906. Available at: http://www.medicareadvocacy.org/medicares-value-based-purchasing-program-for-hospitals-paying-more-to-low-cost-hospitals-that-provide-low-quality-care/.

Sincerely,

CPR Steering Committee

Judith Stein	Center for Medicare Advocacy	JStein@medicareadvocacy.org
Alexandra Bennewith	United Spinal Association	ABennewith@unitedspinal.org
Kim Calder	National Multiple Sclerosis Society	Kim.Calder@nmss.org
Amy Colberg	Brain Injury Association of America	AColberg@biausa.org
Sam Porritt	Falling Forward Foundation	fallingforwardfoundation@gmail.com
Rachel Patterson	Christopher and Dana Reeve Foundation	rpatterson@ChristopherReeve.org

CPR Organizations

Academy of Spinal Cord Injury Professionals
ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Therapeutic Recreation Association
The Arc of the United States
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Easterseals
Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Multiple Sclerosis Society
National Stroke Association
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association

GUNDERSEN
HEALTH SYSTEM®

September 22, 2016

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

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

Re: H.R. 3298—The *Medicare Post-Acute Care Value-Based Purchasing Act* of 2015

Dear Chairman Brady and Representative Kind:

On behalf of Gundersen Health System, we write to provide comments on the updated bi-partisan legislation H.R. 3298—the *Medicare Post-Acute Care Value-Based Purchasing Act*. As a founding member of the Healthcare Quality Coalition, our approach to care delivery is value-based and we strongly support public policies that move away from volume-driven care to one that rewards value. We believe effectively constructed public policy incentives to provide high value care will result in better, more cost-efficient care delivery for patients. Overall, we appreciate the changes made to the updated bill, but additional refinements are necessary to improve the legislation to reward high quality, cost-effective care.

Gundersen Health System provides integrated care for patients along the rural Mississippi River region in western Wisconsin, northeast Iowa, and southeast Minnesota. As the largest employer in the La Crosse, Wisconsin area with over 6,000 employees, Gundersen provides clinical services, level II trauma care, and medical education along with ground ambulance services, and med link air transport. Moreover, Gundersen has consistently achieved top national rankings in many areas of clinical excellence including named as a Healthgrades Top 100 hospital in overall care and many specialty areas.

Gundersen supports the development of value-based reimbursement policy in post-acute care in the Medicare program. We thank you for your bi-partisanship and for engaging stakeholders with the opportunity to provide feedback on further improving H.R. 3298. The bi-partisan bill seeks to build on other quality and performance initiatives to extend the continuum of care toward value-based payment in post-acute settings. We greatly appreciate the outreach and overall are pleased to see some changes suggested were incorporated into the revised and updated legislation.

However, additional modifications are necessary to improve H.R. 3298 before advancing further in the legislative process. Throughout our comments, we make reference to the Hospital Value-based Purchasing program (VBP) as a comparative Medicare value-based payment program that is fully

Gundersen Lutheran Medical Center, Inc. | Gundersen Clinic, Ltd.
External Affairs Department 1900 South Ave., Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundersenhealth.org Phone: (608) 775-1400

implemented under the inpatient prospective payment system. In reviewing the updated draft legislation, on behalf of Gundersen Health System, our top-line comments regarding H.R. 3298 are summarized in the following sections.

Overall, Gundersen Health System **supports** the following provisions:

1. **5% proposed payment risk**
   Payment incentives need to be sufficient and meaningful to drive value-based delivery. We continue to criticize the statutory design of Hospital VBP that set a cap of 2% of payment at-risk, insufficient to drive meaningful reform.[12] We support the proposed 5% payment at-risk so long as the program is modified to be budget neutral. In establishing a transitional period, we recommend the proposed payment withhold be phased-in over a period of 5 years. The amount of payment at-risk needs to be meaningful to drive value-based care, but also be implemented incrementally.

2. **Incorporation of achievement and improvement for VBP scoring**
   The updated language allows for providing performance scoring being the higher of achievement and/or improvement. We recommend the bill direct the implementation through Health and Human Services to employ the same scoring methodology used for Hospital VBP program be incorporated to the PAC VBP. The current Hospital VBP program is familiar and a good model for designing a PAC VBP program, and is designed to reward performance against an established benchmark (achievement) or against own performance (improvement).

3. **Revised language to create different standards for different PAC providers**
   Although the proposed single VBP program includes all PAC providers, we are pleased that language has been added to create separate standards for different PAC providers. Overall, this is a good step. Although we understand and support the goals of VBP, there is wide variation in the clinical scope and service intensity of various PAC providers and settings.

   Providing care for our patients in the most appropriate settings and intervention levels is critical to quick and long-sustained recovery. The appropriate setting of care is determined using clinical standards by the severity of the patient's post-acute care needs. Inpatient Rehabilitation Facilities (IRF) and Skilled Nursing Facilities (SNF) are two very different levels of care treating patients at different stages of recovery. The higher level of focused intensity of treatment provided at an IRF is vital to the success and recovery of patients served as demonstrated in evidence-based benchmarked outcomes. We appreciate this modification and urge its' inclusion in any PAC VBP legislation.

---

[1] Rachel M. Werner and R. Adams Dudley, "Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments," *Health Affairs* 31, no. 9 (2012): 1932, doi:10.1377/hlthaff.2011.0990

[2] U.S. Government Accountability Office, *Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality of Care Trends*, GAO-16-9 (Washington, DC, 2015), http://www.gao.gov/assets/680/672899.pdf

4. **Counting observation services in a hospital toward 3-day inpatient hospital stay requirement for SNF coverage**
   Although not specific to H.R. 3298, language in the chairman's amendment would provide regulatory relief, improve clarity in Medicare coverage, and help our patients receive the right care they need. Current policy creates conflicting goals for the best treatment of patients; although patients are admitted into the hospital under observation which is most clinically appropriate, this causes confusion for patients and families regarding PAC discharge and Medicare coverage, including SNFs. We strongly support including this provision.

To improve H.R. 3298, Gundersen Health System provides the following **recommendations**:

1. **Reflect budget neutrality**
   As currently drafted, even if PAC providers perform well on the program measures and composite scoring, they can only earn back up to 70% withheld that is used to finance the program funding pool. Value-based purchasing programs should be structured in a way for high performing providers and hospitals to achieve a bonus payment. But by design in the bill, strong performance linked to inevitable payment reductions would take on a penalty-oriented program rather than a value-based initiative. Even if providers perform very well, they will still be subject to a payment reduction, which is not sound policy. Revising the legislation to a budget neutral program would reflect similarly to Hospital VBP and be a better policy directive. We strongly oppose the current financing structure and request the withhold and re-distribution policy align with Hospital VBP.

2. **Removal of the geographic resource use measure comparison**
   During the first two years of the PAC VBP program as proposed, 45 percent of an individual provider's VBP performance would rely on the performance of all other PAC providers in the same hospital referral area. Linking a particular PAC provider's performance on the Medicare spending per beneficiary (MSPB) measure to the performance of other dissimilar PAC providers is not appropriate. This provision would hold that particular provider responsible for operational decisions occurring in very different care settings and Medicare payment systems. In practice, a treatment plan developed by an IRF is not transferable to a SNF unless the patient is ready for less intensive therapy for their recovery. The geographic scope of the bill does not promote valid provider comparison.

   The Institute of Medicine report on Geographic Variation in Healthcare Spending also cautions against using a geographic-based value index, and rather should be focused on providers, provider groups, and hospitals.[3] As such, we oppose the inclusion of the hospital referral area clause as part of the PAC VBP resource use comparison. Instead, we recommend the entire weight of resource use/spending measures be at the provider or facility level due the varying differences in care intensity and services across PAC providers.

[3] Institute of Medicine. *"The Study of Geographic Variation in Healthcare Spending and Promotion of High Value Care."* (July 2013). http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2013/Geographic-Variation2/geovariation_rb.pdf

3. **Greater emphasis on quality outcomes balanced with resource use**
   To achieve a value-based program as a reflection of cost and quality, we ask the bill reflect balanced weighting of the measures. We support value-based care as a function of quality and cost equally weighted. Although functional status is an important metric in PAC, using functional status alone does not fully reflect quality outcomes. Functional status is a narrow glimpse at a patient when so many other facets of care contribute to quality outcomes.

   Additionally, the implementation of functional status measures is just beginning as a component of quality reporting and improvement. Enacting PAC VBP by emphasizing resource use without a balance of quality measures does not reflect value-based policy. Also, without the opportunity to collect data and refine the current PAC measure sets would be premature. There is still much work to be done to determine Functional outcomes that are meaningful and reflective of quality and potential for improvement in the various PAC settings. Each PAC setting has very different levels of service use and intensity and if the current measures just staring to be implemented are not addressed PAC providers would be using information that does not reflect adequate or even appropriate measures of functional status.

4. **Utilize the existing PAC Quality Reporting Programs (QRPs) and follow the *Improving Medicare Post-Acute Care Transformation (IMPACT)* Act process for incorporating appropriate cross-setting measures.**
   Gundersen urges that changes be made to H.R. 3298 to adhere to the IMPACT Act's implementation timeline. Following the IMPACT Act process ensures cross-setting measures that would be necessary for implementing H.R. 3298 have been fully developed, vetted, endorsed by the National Quality Forum (NQF), and validated. It is important that IMPACT Act measures are fully implemented before VBP adjustments are enacted.

   The PAC VBP should be implemented once outcome measures, as required by the IMPACT Act, are proposed and included in quality reporting prior for a period of time prior to inclusion in VBP. The IMPACT Act offers several other quality domains which could contribute to a more robust assessment of PAC provider quality. We urge these and other traditional quality metrics to be considered for inclusion in any PAC VBP rather that only functional status. In addition, Gundersen recommends the bill direct Health and Human Services to use the PAC QRP as s steppingstone for VBP. Establishing a minimum one year of measure reporting prior to incorporation into the PAC VBP program would align with the Hospital VBP and other programs. We support this approach used in Hospital VBP.

Conclusion

On behalf of Gundersen Health System, we greatly appreciate your continued support of advancing innovative, value-based payment programs and support for high quality care. We are supportive of

continued efforts to advance value-based care forward. We appreciate modifications made to the legislation, but refinements and improvements are critical before further advancement.

To schedule a visit to our IRF or if you have any questions or need clarification, please feel free to contact us at any time.

Sincerely,

Michael D. Richards
Executive Director of External Affairs
Gundersen Health System

Deborah Head
Rehab Program Manager
Gundersen Health System

September 20, 2016

The Honorable Pat Tiberi
Chair
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Committee on Ways & Means, Subcommittee on Health
U.S. House of Representatives
1106 Longworth House Office Building
Washington, DC 20515

Re: Testimony in response to Ways and Means Health Subcommittee hearing *"The Evolution of Quality in Medicare Part A"*

Dear Chairman Tiberi & Ranking Member McDermott:

On behalf of the Healthcare Quality Coalition (HQC) we are writing to provide testimony in response to the September 7th, 2016 House of Representatives Ways and Means Subcommittee on Health Hearing entitled "The Evolution of Quality in Medicare Part A." Following last year's enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) to further advance value in Medicare Part B, we are pleased the subcommittee is examining programs and policy issues for advancing quality improvement and value-based care in Medicare Part A.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Our provider systems have more than 19,000 licensed hospital beds, more than 21,000 physicians, and 225,000 employees across the country. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value and are pleased to provide input on improving existing and creating future hospital performance and value-based reimbursement

Hospital Value-Based Payment Reform Policy

The HQC strives to provide meaningful input on improving existing programs to drive value-based care forward while offering new ideas for further program development. As outlined, the HQC offers a series of steps for streamlining and improving existing value-based programs into an improved Hospital Value-based Purchasing Program. The new Hospital Value-based Purchasing program would align with the overarching framework and general approach of the MACRA law: collapse existing separate, siloed programs into a single value-based payment initiative while providing incentives for alternative payment models.

Guiding Principles

- Reform, streamline, and improve existing penalty-only programs into an enhanced Hospital Value-Based Purchasing Program, offering incentives and rewards for high performance
- Advance value-based care by increasing the amount of payment tied to hospital performance
- Improve efficiency as a unit of *value* by modifying the improved Hospital Value-Based Purchasing program to weigh measures of cost and quality equally
- Eliminate overlap with quality measures between separate hospital programs
- Provide opportunities and incentives for developing and expanding hospital-focused Alternative Payment Models

Step 1: Improve existing Medicare Hospital Penalty Programs

The HQC supports comprehensive value-based payment policies that integrate risk and offer rewards to hospitals that lead in improving patient experience, outcomes, and reducing the cost of care. We strongly believe properly structured payment reforms have an opportunity to significantly reduce the cost of care. However, performance-based programs that only assess penalties fall short of comprehensive value-based models. Reforming existing penalty programs to incent value by consolidating into a single Hospital Value-Based Purchasing program would align incentives, reduce duplication, and increase overall impact of the independent programs.

In the Hospital Readmissions Reduction (HRR) program, hospitals are compared to average performance of hospitals with similar patient case mix. In FY 2016, over 75% of eligible hospitals in the nation were subject to some level of readmissions penalty (maximum -3%), totaling over $420 million despite drops in national readmission rates.[1] [2] Meanwhile, the Hospital-Acquired Conditions (HAC) Reduction program assesses a 1% penalty for hospitals with the highest quartile rates of infections, injuries, and illnesses. Even though there has been a 17% national reduction in HACs[3] from 2010-2013, as designed, the HAC Reduction program will penalize 25% of hospitals every year,

[1] Sabriya Rice, "Most hospitals face 30-day readmissions penalty in fiscal 2016," *Modern Healthcare*, August 3, 2015, http://www.modernhealthcare.com/article/20150803/NEWS/150809981

[2] Jordan Rau, "Half Of Nation's Hospitals Fail Again To Escape Medicare's Readmission Penalties," *Kaiser Health News*, August 3, 2015 http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/

[3] Agency for Healthcare Research and Quality, *2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013*, AHRQ Publication No. 16-0006-EF (Rockville, MD, 2015), http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/hacrate2013.pdf

regardless of improvement. Further, like the Hospital Readmissions Reduction initiative, the HAC program is penalty-only.

While the HRR and HAC initiatives are designed to improve quality and reduce unnecessary spending, both are penalty-only programs, and do not provide positive incentives for high-quality, cost-effective care. Furthermore, as structured, the programs base performance on national averages, meaning hospitals may continue to be penalized even if they improve their readmission, infection, or safety rates. Finally, some measures are used in multiple programs, such as infection measures which result in overlap. Reforming the penalty-only structure of the program and consolidating into the Hospital Value-Based Purchasing program provides better incentives and eliminates the overlap and duplication of quality measures.

Despite structural issues, throughout implementation, the HQC has provided feedback to CMS on suggested refinements to HRR and HAC programs. Risk-adjustment is a critical component of any quality and pay-for-performance program and essential for fair comparisons among providers of healthcare services when factors beyond their control influence patient outcomes. As supported by many stakeholders, we believe CMS should take steps to incorporate sociodemographic factors in risk adjustment methodology for the HRR program. This is especially important for hospitals serving rural areas that may be unfairly penalized for readmissions. The HQC also urged CMS not to further increase patient populations in other measure sets in HRR unless it is made part of a broader value-based program, which is the core outcome of a new consolidated, streamlined program. Changes to improve the existing programs before consolidating into a new payment initiative will ensure fairness and further improve and advance value-based care.

Step 2: Streamline and Enhance the Hospital Value-Based Purchasing (VBP) Program

The HQC supports the goals of the hospital VBP program to reward high quality hospitals and to incentivize performance improvement.[4] Overall, the HQC believes hospital VBP is moving in a positive direction by emphasizing patient outcomes, assessing payment adjustments by actual performance, incorporating achievement and improvement performance, and maintaining the current weighting of efficiency and cost reduction metrics. Continued emphasis needs to be focused not on the number of quality and cost measures, but on measures that are attributed to patient outcomes.

Consolidating existing penalty programs into an improved Hospital VBP program will streamline existing value and performance-based initiatives. Combining separate programs into a single value-based payment initiative will also remove overlap and redundancy. While the HQC supports alignment with other initiatives, we continue to oppose measures that overlap and are redundant with other related performance programs, including HAC and HRR. Overlapping measures with programs outside of Hospital VBP may introduce redundancy, confusion, and contrasting goals. Bringing all the performance programs together rolled up into Hospital VBP will alleviate these concerns.

---

[4] Daniel Blumenthal and Anupam B. Jena, "Hospital value-based purchasing," *Journal of Hospital Medicine* 8, no. 5 (2013): 271, doi:10.1002/jhm.2045

In addition to streamlining current performance and penalty programs, the current statutory structure of the Hospital VBP program is ineffective in driving meaningful reform. The incentive amounts are small, payment differentiation is minimal, and is not sufficient to drive meaningful changes in hospital care.[5,6] The current 2% statutory cap on incentives will not sufficiently motivate hospitals to strive toward value-based care delivery. Removing the ceiling will link more payment to value and drive quality improvement forward.

In addition to removing the statutory cap on Hospital VBP, the HQC continues to support value as an equal reflection of cost and quality. Currently, the VBP program includes efficiency and cost reduction measures weighted at 25%. To further improve the program, we recommend the following steps: 1) Develop and implement a plan to increase the weight of efficiency and cost reduction domain; and 2) Incorporate additional risk-adjusted measures of efficiency in addition to the current Medicare Spending per Beneficiary (MSPB) metric.

In the implementation of MACRA focused on Medicare Part B, CMS proposed additional measures of resource use (efficiency) to help address the issue of balancing both cost and quality measures in the Merit-based incentive payment system (MIPS). This approach needs to be followed for hospital measures of cost/efficiency that align with physician/clinical services. We believe value-based care models need measures that are meaningful and aligned with inpatient and outpatient/ambulatory services.

Step 3: Develop and expand voluntary hospital Alternative Payment Models

There are currently an array of programs and initiatives aimed at reducing cost and improving quality, including Accountable Care Organizations (ACOs), bundled payment, and Patient-Centered Medical Homes. Although the Medicare ACO program has demonstrated mixed results,[7] experience from providers and hospitals participating as an ACO and other innovative models are integral for developing improved payment policy. In addition, the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) was a milestone in Medicare physician payment policy. Not only did the MACRA repeal the antiquated Sustainable Growth Rate formula, the law drives value-based care through streamlined existing programs and new payment models. Improved hospital payment policy should take a similar conceptual approach, providing statutory authority for encouraging and financially incentivizing hospitals to undertake new models of care with opportunities for improved integration with clinical services.

In providing opportunities for future hospital alternative payment models to flourish, we ask lawmakers to follow these guiding principles:

---

[5] Rachel M. Werner and R. Adams Dudley, "Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments," *Health Affairs* 31, no. 9 (2012): 1932, doi:10.1377/hlthaff.2011.0990

[6] U.S. Government Accountability Office, *Hospital Value-Based Purchasing: Initial Results Show Modest Effects on Medicare Payments and No Apparent Change in Quality of Care Trends*, GAO-16-9 (Washington, DC, 2015), http://www.gao.gov/assets/680/672899.pdf

[7] David Muhlestein, "Medicare ACO's: Mixed initial results and cautious optimism," *Health Affairs Blog*, February 4, 2014, http://healthaffairs.org/blog/2014/02/04/medicare-acos-mixed-initial-results-and-cautious-optimism/

- Hospitals should have the opportunity to take on risk—rewarding quality and efficiency.
- Incentivize coordinated care and build on existing initiatives and infrastructure.
- Capitated-based reimbursement and incentive payments should be a core component of alternative payment models.
- Flexibility and proper tools are essential to improve quality and reduce cost, including provider and hospital networks.
- Beneficiaries should be engaged in delivery system reform, such as patient involvement and understanding their stake in value-based outcomes.

Conclusion

On behalf of the HQC, we appreciate the Ways and Means Subcommittee on Health focusing on hospital quality and value-based care in Medicare Part A. We urge the committee to consider ways to consolidate and streamline existing value-based and penalty programs into an improved payment program similar to the concepts in MACRA for Medicare Part B. Medicare Part A and Part B value-based programs working in tandem will not only streamline operations, simplify measure reporting, but further drive value-based care forward.

Please feel free to contact us with any questions.

Sincerely,

The Healthcare Quality Coalition

www.qualitycoalition.net info@qualitycoalition.net (608) 775-1400

September 20, 2016

The Honorable Kevin Brady
Chair
Health Subcommittee
U.S. House Ways and Means Committee
1135 Rayburn House Office Building
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representative
1502 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Rep. Kind:

On behalf of LeadingAge, I appreciate the opportunity to provide our comments on value-based purchasing for skilled nursing facilities under the Medicare program. These comments supplement the letter we co-signed that was submitted by the PAC community on September 15, 2016.

The members of LeadingAge and its affiliates impact the lives of 4 million individuals, family members, employees and volunteers every day. Our 6,000+ members and partners include not-for-profit organizations representing the entire field of aging services, 39 state associations, hundreds of businesses, consumer groups, foundations and research centers. Our members, all of which are not-for-profit and most of which are faith-based, have been in the forefront of providing housing and long-term services and supports to older Americans for over 100 years.

We supported the skilled nursing facility value-based purchasing initiative already enacted as part of the Protecting Access to Medicare Act of 2014. This initiative, now being implemented by the Centers for Medicare and Medicaid Services (CMS), will "withhold" a percentage of Medicare payments to nursing homes. Nursing homes that provide high-quality care will be able to earn back part but not all of the withheld reimbursement. We supported the concepts behind the present value-based purchasing program because it measures reduction in avoidable re-hospitalizations, a measurable indication of quality.

The implementation of the current skilled nursing facility value-based program is a central step in the conversion of Medicare payments for health care services to reward better value, outcomes, and innovations. We recognize the importance of transitioning from rewarding volume to rewarding improvements in population health and enhancing the value of services and have long supported transparency in meaningful, person-centered quality measures and the valuation through payment of high quality services.

LeadingAge supports the concept of payment that reflects true quality. But in the rush to move to value-based payment models, we want to be sure that the measures are truly valid measures of quality, and that they reflect the risk differences between individuals and providers. The "withhold" should be sufficient to fund the incentive program, but not such that small, financially challenged providers are unduly disadvantaged.

We also strongly believe that the greatest possible percentage of withheld payments should be returned back to providers in the form of incentives. These incentives should be distributed timely and in a way that links to the actual performance being rewarded. The distribution strategy should not just reward high volume providers with low risk/low acuity patients, but truly reflect meaningful quality and account for

complexity of care needs and unique challenges of rural and under-served area providers. Lastly, we recognize that some of the best providers of post-acute care, our LeadingAge members, and a payment strategy that rewards true quality of care will be a win for those who stand out as excellent.

On the other hand, we are concerned about some value-based purchasing proposals' potential to create unintended consequences. These may include providers being unduly "punished" when measures are not appropriately risk adjusted, providers failing to report events for fear of losing reimbursement, or providers simply avoiding high risk, high complex care patients.

Under the current value-based purchasing initiative, 2% of Medicare reimbursement will be withheld from skilled nursing facilities. Even the highest-performing facilities will not recover all of the funding withheld from them.

More recent value-based purchasing proposals we have seen, including H.R. 3298, call for a far higher percentage of withholding, up to 8 percent. As with the current initiative, nursing homes would not be able earn back all the amounts withheld even if they met or exceeded the required measures. This withhold is excessive and would remove resources skilled nursing facilities need to achieve the quality that policymakers, consumers and providers want from the post-acute care system.

Value-based purchasing as enacted in 2014 was made to serve a larger end than improvement in post-acute care; the payment withholds became a means of offsetting the cost of reforming the Medicare physician payment system. As other proposals for Medicare cost containment are considered, care must be taken to ensure that value-based purchasing does not become a mechanism for cutting too deeply the reimbursement providers need to cover the essential costs of their services.

Other cost-control and efficiency initiatives to which providers are already subject also need to be taken into account. Annual Medicare payment updates are subject to 2% Medicare sequestration, which will last through 2025. CMS now is implementing the IMPACT Act of 2014, which will measure quality of care and Medicare spending per beneficiary across the four categories of post-acute care covered by Medicare. The Bundled Payments for Care Improvement initiative, currently being expanded, is a service delivery reform that incentivizes health and post-acute care providers to work together to ensure high-quality, cost-effective care for Medicare beneficiaries. The same is true of the development of accountable care organizations and other payment system innovations.

All of these initiatives already in effect are requiring skilled nursing facilities to rethink the way they deliver services, and become more cost-efficient while maintaining quality of care. Congress should allow the work already under way on these initiatives to continue rather than throwing away progress already close to achievement.

The LeadingAge Public Policy Congress has outlined principles for implementation of value-based purchasing, which we hope will be helpful to your committee:

1) The administrative burden on providers must be minimized.
   - Data collection should incorporate relevant, existing, quality-related databases to the degree possible.
   - Data collection should focus on evidence-based, scientifically provable behaviors, processes and outcomes.

2) Successful implementation requires an appropriate infrastructure (such as electronic records).
   - Information technology must support quality care and include efficiencies that allow for more time dedicated to direct care.
   - Information technology should support the ability to link quality measures to actual performance, separate from survey or customer satisfaction data.

- Similar to Medicare VBP for physicians and hospitals, VBP for nursing homes and other post-acute care providers should include added compensation for meaningful use of technology, particularly for small, rural providers.
- System infrastructure should be designed to support the ability to communicate across settings.

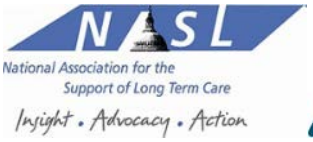
3) A feasible, credible validation process is required.
   - The validation process must be standardized and uniform across states.

4) An appropriate public reporting system must be developed.
   - Just as the individual VBP measures must be credible, reliable and validated, with a transparent process governing their adoption, so too must be the system for public reporting of performance results.
   - Developing a valid public reporting system requires more meaningful expert and stakeholder participation than has been the case with the current reporting system.

In conclusion, "value" cannot be achieved by withholding the resources nursing homes need to hire staff and meet other essential expenses. Implementation of value-based purchasing and related initiatives must be a thoughtful, considered process with measures ensured of validity and reliability. The shift from volume to value-based payment is a laudable goal, as long as it includes quality measures that are properly tested and refined before implementation. And the work already in progress at CMS should be allowed to continue, not replaced with a new initiative simply for the sake of cutting Medicare spending on post-acute care.

Sincerely,

Cheryl Phillips, MD
Senior Vice President, Public Policy and Health Services 202-508-9470
cphillips@leadingage.org



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

Statement for the Record
Ways & Means Subcommittee on Health
U.S. House of Representatives
Chairman Pat Tiberi (R-OH) & Ranking Member Jim McDermott (D-WA)
"The Evolution of Quality in Medicare Part A" Hearing
Wednesday, September 7, 2016

Submitted by John Richardson
Executive Director, Physician Hospitals of America

Dear Chairman Tiberi, Ranking Member McDermott, and distinguished members of the Subcommittee,

On behalf of the Physician Hospitals of America (PHA) and the approximately 250 physician-owned hospitals (POHs) across the country, thank you for the opportunity to submit a statement for the record on improving care quality in Medicare Part A.

While this hearing did not directly address the issue of physician-owned hospitals (POHs), any discussion of improving healthcare quality should include an examination of the benefits and merits of physician ownership of hospitals. POHs provide just the kind of high-quality care that Chairman Tiberi highlighted in his opening remarks, yet current law prohibits POHs from being able to compete to treat the growing population of Medicare and Medicaid patients in their communities. This policy is bad for healthcare quality, bad for the Medicare Part A program, and bad for patients.

Multiple independent, peer-reviewed studies and government quality ratings programs have demonstrated that POHs are centers of excellence, leading the way in quality, patient satisfaction, and costs. The facts so clearly point to the high performance of POHs that the authors of a study in *BMJ*, titled "Access, Quality & Costs of Care at Physician-Owned Hospitals in the United States," concluded that there is "a need to re-examine existing public policies that target all hospitals with physician owners." The study was the first of its kind to comprehensively examine the patient mix at POHs and non-POHs and the researchers from Massachusetts General Hospital and Harvard found both types of hospitals see similar patient populations.

Congress should allow POHs to compete on a level playing field with every other hospital in the country by enacting the reasonable, common sense provisions included in H.R. 2513. This bipartisan legislation, introduced by Rep. Sam Johnson (R-TX), will improve and sustain the Medicare program by allowing existing POHs to expand to meet their communities' demand for high-quality, low-cost health care services.

Quality

Existing government programs that reward hospitals for high-quality care, or penalize them for low performance, have shown that POHs consistently outperform their competition.

Hospital Value-Based Purchasing Program
Beginning in FY 2013, the Centers for Medicare and Medicaid Services (CMS) established the Hospital Value-Based Purchasing (VBP) program to award and penalize hospitals across the country for quality of care. Medicare payments to the more than 3,500 participating hospitals are increased or reduced based upon performance in measured domains for care quality, including patient experience, outcomes, process of care and efficiency.

POHs consistently outperform their non-POH competition in the VBP program. In FY 2016, seven (7) of the top ten (10) hospitals in the program were POHs. 79% of POHs received a bonus payment adjustment, compared to only 58% of non-POHs.

Readmissions Reduction Program
Effective on October 1, 2012, CMS reduces payments to hospitals participating in the Readmissions Reduction (RR) program for excessive readmissions of patients to a hospital within 30 days of a discharge.

As with the VBP program, POHs consistently outperform their non-POH counterparts. In FY 2016, 55% of POHs received no penalty for readmissions, compared to only 18% of non-POHs.

Star Ratings for Patient Satisfaction
In 2015, CMS began issuing summary star ratings for hospitals' patient satisfaction scores. The star ratings allow patients to compare performance between nearly 3,500 Medicare-certified hospitals on a wide array of metrics evaluated in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, including communication with nurses and doctors, pain management, staff responsiveness, care transition, hospital cleanliness and quietness, etc.

These star ratings are issued quarterly, beginning with April 2015. In each of the reported quarters thus far, POHs have displayed unparalleled patient satisfaction through their consistently high star ratings. In the initial April 2015 release, over 41% of POHs received a 5-star rating compared to only 5% of non-POHs.

Overall Hospital Quality Star Ratings
In July 2016, CMS began releasing star ratings for overall hospital quality. These new star ratings, which are intended to simplify the process of comparing hospitals and interpreting complex quality information, converts data from existing quality measures that are publicly reported into a single rating for each hospital.

Of the 102 hospitals in the nation that received the highest 5-star rating, 37 were POHs - an impressive feat given that POHs only comprise approximately 5% of the total number of hospitals nationwide. In fact, more than half of the POHs evaluated in this new star rating program received a 4- or 5-star rating.

Value

In addition to providing high-quality care, POHs also reduce costs for patients and the Medicare program. Despite claims by opponents of the POH industry that these hospitals increase costs, a study by Avalon Health Economics found that POHs save Medicare $3.2 billion over 10 years. We know this as CMS has started to publish actual payments to hospitals. Comparative analysis found that the average payment to POHs is significantly less than those made to competitor hospitals in the same referral region. It would cost Medicare $3.2 billion more if the cases at POHs shifted to a non-POH. And if the costs of higher readmissions and infections are added to the formula the savings may be three times as great.,

H.R. 2513

Introduced by Rep. Sam Johnson (R-TX) with bipartisan support, H.R. 2513 - the Promoting Access, Competition and Equity (PACE) Act of 2015 - is an important, patient-centric piece of legislation that would improve patients' access to some of the highest quality, lowest cost hospitals in the country: POHs.

H.R. 2513 would address the most egregious aspects of the ACA moratorium on POHs by providing a reasonable pathway for higher quality POHs to apply for an exception to expand facility capacity and allow hospitals that missed the arbitrary deadline for Medicare certification as a POH to be grandfathered under the law.

Specifically, H.R. 2513 would:

- **Allow POHs to apply for expansion if they receive at least 3 stars from CMS in the new Summary Star Ratings program for hospitals over 3 consecutive years.** The bill is sound public policy - tying expansion to quality outcomes and the overall patient experience - it should apply for *all* hospitals. Why should Congress allow a hospital to expand if they provide poor quality of care? Poor quality increases costs, but more importantly causes harm to patients. Hospitals that are 1- and 2-star facilities invariably are hurting patients physically as well as financially. They certainly cost Medicare more money. Hospitals with physician ownership, through H.R. 2513, have offered to be held to a higher standard for quality of care, but all hospitals should submit to this concept as it would increase quality for all. This patient-first idea is indicative of the POH industry.
- **Grandfather two hospitals that were under development as POHs when the ACA was passed but were unable to meet the arbitrary Medicare certification deadline**.

Patients should be able to seek treatment at the hospital of their choice and Medicare should embrace hospitals that provide high quality care and that save the system money. H.R. 2513 will move us towards this goal by holding POHs to a higher standard, ensuring the best outcomes for patients and thereby setting an example for the entire system.

Conclusion

Medicare patients throughout the nation know the benefits of POHs firsthand. They choose to go to POHs because they know they will receive excellent care and have good outcomes. Patients deserve the choice of a high-quality, low-cost facility, and that is what PHA and the POH industry are fighting for.

As POHs treat similar patient populations with higher quality outcomes, better patient experience, and lower costs of care, we respectfully request that Congress remove the onerous restrictions on POH expansion and give patients more freedom of choice in where they receive care. As the authors of the BMJ study stated, Congress should "re-examine existing public policies that target all hospitals with physician owners" and enact common sense reforms. The current POH policy is bad for patients and bad for Medicare.

Thank you again for the opportunity to submit this statement for the record. I look forward to working with Congress to enact H.R. 2513.

Sincerely,

John Richardson
Executive Director, Physician Hospitals of America

September 21, 2016

The Honorable Kevin Brady
United States House of Representatives
301 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Brady:

The Texas Association for Home Care and Hospice (TAHC&H) thanks you for your ongoing work to improve the Medicare program through innovations in efficiency and quality that safeguard taxpayers' dollars. We appreciate the opportunity to provide input into your recently revised legislation, H.R. 3298 the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015*.

The Association represents over 1,300 licensed home care and hospice agencies in Texas. Our mission is to advocate for ethical practices, quality, and economic viability of licensed providers in Texas. Our membership, like Texas, is very diverse and includes home care agencies from rural and urban areas, both large and small. Some agencies are very close to readiness for value-based purchasing (VBP). Other smaller or family-owned agencies will face significant challenges to adopt this and other payment models. Our association represents all of these unique perspectives.

We would like to thank you for your leadership and ongoing work with stakeholders to improve this bill. It is a topic our Membership has been discussing for some time and we are grateful to continue to provide our perspective as Congress considers improving efficiency in the Medicare program. We commend your interest and focus in reforming post-acute care as Chairman of the full House Ways & Means Committee. Overall we are encouraged that the legislation offers a more reasonable and workable approach than the one offered by Centers for Medicare and Medicaid Services (CMS) in their proposed Home Health Prospective Payment System (HHPPS) rule and appreciate the modifications you have made so far in response to stakeholder input. We are also most appreciative of some of the regulatory relief being contemplated by the Committee as it relates to "face-to-face" and CMS's recently announced demonstration targeting Texas related to pre-claim review.

There are many concerns and challenges that both our Association and you have identified with CMS's approach, in particular the need for a gradual, phased-in approach to allow providers to make adjustments to their business practices and employ new technologies. In contrast, the approach taken by CMS is too aggressive and threatens patient access to care.

While much is contemplated in H.R. 3298, our comments focus on a few overarching themes which are consistent with the Association's previous comments, public statements and letters related to VBP. Those include:

- Cost Savings
- Quality Measures
- Provider Performance
- Withhold
- Timeline

Texas Association for Home Care & Hospice
3737 Executive Center Dr., Ste 268 ★ Austin, TX, 78731 ★ (512) 338-9293 ★ f (512) 338-9496 tahch.org ★ my.tahch.org ★ myhomecarechoices.org

Cost savings
H.R. 3298 reduces the aggregate amount Medicare pays to all post-acute care providers and we are concerned about the level of these reductions. From our interpretation of the legislation, home health agencies will face two years of cuts before any quality measures are considered. Of money withheld from provider payments, 50 - 70% will be returned to providers for incentive payments; the remainder will be absorbed as cost-savings. This amounts to another cut to home care services as the money is not re-invested in the program. It is TAHC&H's position that: (1) the legislation should achieve Medicare savings through improving clinical quality, reducing hospital readmissions and improving efficiency; and (2) **all money withheld from provider payments should be returned to the program in the form of incentive payments to encourage those providing high quality care.**

Quality Measures
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.

We continue to believe that Medicare Spending per Beneficiary (MSPB) is an efficiency measure and not a quality measure. One efficiency measure alone is not a good key indicator of quality or value. Therefore, we ask that any VBP proposal should consider a "vital few" (4-5) measures that reflect clinical quality and indicate the improved health of home care recipients. For instance, much work is being done on outcomes measures as it relates to the implementation of the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*. We believe that it would be better to wait to implement PAC VBP when IMPACT Act measures have been tested and shown to be good indicators of quality across post-acute settings.

In addition, measures must be risk-adjusted to account for factors such as case-mix, offering flexibility for providers that may specialize in a high-acuity patients or who operate in regions where the overall population is less healthy due to lack of access to health care or economic disparities.

Last, 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.

Provider Performance
In our reading of H.R. 3298, we interpret the language to mean the Secretary shall measure performance in three ways:

- Each individual PAC provider;
- Each hospital area, or other equivalent area; and
- PAC "composite" performance assessment equal to the sum of 55% (performance score for the individual PAC provider) and 45% (performance score for all PAC providers in the area) during the period.

First, our Association is still evaluating the suggested methodology behind calculating the individual performance scores. We are trying to understand the potential impact of using "the higher of either achievement or improvement" as performance standards. It is possible that a blended approach might be better. We would like to discuss this with you further.

Second, we seek clarification on the role of the regional variable as part of ranking the composite PAC performance scores. How is this going to influence payments? Is this meant to adjust for socio-economic variables unique to a region? Why are hospital districts proposed versus using the state as a region? Although we understand the relationship between hospital spending and post-acute care, it is very hard to conceptualize how providers will be grouped in these "hospital referral areas." Home health agencies may receive referrals from multiple hospitals – particularly statewide or multi-state HHAs. How will their performance score be calculated? Or will they have multiple provider scores by hospital?

Third, TAHC&H appreciates the change prohibiting cross PAC provider comparisons.

Withhold
Any withhold should be commensurate with what other provider types are experiencing with Value Based Purchasing in other parts of Medicare. For hospitals, VBP began in FY 2013 with a 1.0% withhold; moving to 1.25% in 2014; 1.5% in 2015; 1.75 in 2016; and 2% for FY 2017 and subsequent years. A two percent withhold is the maximum that *any* other provider group has experienced thus far.

Although we appreciate the change reducing the withhold to 5%, this remains too substantial and significantly more than any other VBP program. We continue to believe this would particularly endanger smaller agencies in the rural parts of Texas that are already operating on slim margins. These smaller agencies are less equipped to invest in the new technology and software required to conduct data analytics and modeling required by VBP.

All home care agencies are struggling with the pressures of home health rebasing payment cuts and massive cash-flow problems due to CMS regulations, including face-to-face requirements. Most recently CMS has implemented a demonstration program called "Pre-Claim Review" that has proved disastrous for Illinois, the first state of five (including Texas) to implement this demonstration. As a result, some agencies are closing and many are laying-off staff. A sudden and significant payment risk-factor of 5% could do more harm than good. TAHC&H continues to recommend a graduated withhold amount no greater than 2%.

In conclusion, we would welcome the opportunity to keep working with you and your Committee on alternative payment models that support quality and efficiency while ensuring the sustainability of home health as a care option for Medicare beneficiaries. Home health is by nature a cost-saver to the Medicare program and the preferred care option of patients. If we can, through VBP, improve patient outcomes, promote good transitions of care amongst provider types, ensure a quality and robust provider base and increase health care integration, then VBP will be viewed as successful.

Thank you for all you do for Texas and the United States and for your "open-door" in providing input and comments, it is very much appreciated. Please do not hesitate to contact me with any questions or to discuss this letter further or if I can provide any additional information.

Sincerely,

Rachel Hammon, RN, BSN, Executive Director

BRAIN INJURY ASSOCIATION OF AMERICA

1608 Spring Hill Road | Suite 110 | Vienna, VA 22182
Phone: (703) 761-0750 | Fax: (703) 761-0755
www.biausa.org

THE VOICE OF BRAIN INJURY

September 20, 2016

SENT BY ELECTRONIC MAIL

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

The Honorable Sander M. Levin
Ranking Member
House Committee on Ways and Means
1236 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

The Honorable Jim McDermott
Ranking Member
House Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

Re: Medicare Post-Acute Care Value-Based Purchasing Act of 2015 (H.R. 3298)

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

The Brain Injury Association of America (BIAA) is the nation's oldest and largest brain injury patient advocacy organization. We are the voice for an estimated 3.5 million Americans who acquire a brain injury each year as a result of trauma, stroke, seizures, infectious diseases, metabolic disorders, tumors, vascular conditions, toxic exposure, and oxygen deprivation.

This letter addresses our comments to the *Medicare Post-Acute Care Value-Based Purchasing Act of 2015* (H.R. 3298). We believe that any post-acute care value-based purchasing (PAC-VBP) legislation needs to focus primarily on incentivizing high quality care and the achievement of good outcomes for individuals with injuries, illnesses, disabilities and chronic conditions in post-acute care settings, including individuals with brain injuries.

Our major concern with the current version of this bill involves the Medicare Spending per Beneficiary ("MSPB") measure. According to Ways and Means Committee correspondence to Secretary Burwell in July of last year, it is the only measure contemplated under H.R. 3298.[1] A series of legislative changes to this bill were recently shared with PAC provider stakeholders. Among the changes to the bill was the inclusion of one additional measure on function, scheduled to take effect two years after implementation of the MSPB measure.

[1] Letter from Chairman Brady and Rep. Kind to HHS Secretary Silvia Burwell, House Ways and Means Committee Website, July 29, 2015. Appendix A states, "H.R. 3298 proposes to use one quality measure--the Medicare Spending Per Beneficiary (MSPB) measure....Rather than dictate which aspects of care are important, H.R. 3298 sets one clear performance target and allows providers to choose for themselves what to focus on in order to achieve a singular outcome."

MSPB is an economic measure to assess Medicare utilization and is used to distinguish between efficient and inefficient providers within a given setting. It does not measure duration, scope or intensity of health care services provided to patients, patient outcomes, or quality of care. MSPB fails to adequately recognize patient severity, the level or resources provided to meet patient needs, and the functional gains to be achieved through higher intensity, coordinated, multidisciplinary rehabilitation for Medicare beneficiaries with brain injuries and other serious conditions.

Therefore, the addition of one functional measure, while clearly imperative to both incentivizing quality improvement and permitting CMS to understand what it is getting in return for its payments to providers, is wholly inadequate to measure quality and outcomes of a wide variety of Medicare beneficiaries with brain injuries and other injuries with varying levels of injury severity across very different PAC settings. Not only are a significant number of validated functional outcome and quality of life measures needed in any PAC-VBP system, but other measures that address quality of care and quality improvement are critical as well.

BIAA believes that H.R. 3298, as currently contemplated, would almost singularly promote efficiency of treatment and reduction in PAC spending, and has the likely potential of driving patients to less costly, less intense rehabilitation settings without sufficient deference to their medical and functional needs. The current PAC VBP legislation does not appear to truly focus on improvement of quality and patient outcomes, and is much more targeted on lessening the cost of PAC services.

We strongly urge the subcommittee to comprehensively reconsider this legislation to ensure that any PAC-VBP bill that moves through Congress is designed to achieve the health care quality goals that value-based purchasing is intended to accomplish. Any PAC-VBP bill that becomes law must have robust quality and functional measures as well as accurate risk adjusters as its foundation to prevent against underserving patients, particularly individuals with brain injuries.

****

We greatly appreciate your attention to our comments. Should you have further questions regarding this information, please contact me at your convenience at the number listed above or at shconnors@biausa.org.

Sincerely,

Susan H. Connors
President/CEO