September 21, 2016

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

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

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

Dear Chairman Brady, Rep. Kind and Chairman Tiberi,

The American Academy of Physical Medicine & Rehabilitation (AAMP&R) is a national medical society representing more than 9,000 physiatrists who treat adults and children with acute and chronic pain; persons who have experienced catastrophic injuries resulting in paraplegia, quadriplegia, traumatic brain injury, spinal cord injury, limb amputations, and musculoskeletal injuries; and individuals with neurologic disorders, rheumatologic conditions, or any other disease process that results in impairment and/or disability. With appropriate rehabilitation, many patients can regain significant function and live independent and fulfilling lives.

Physiatrists work across the entire post-acute care (PAC) continuum and utilize cutting-edge as well as time-tested treatments to maximize function and quality of life. They are well positioned to assess the medical and rehabilitation needs of patients in order to determine whether, and when, to send a particular patient to a long-term acute care hospital (LTACH), an IRF, a skilled nursing facility (SNF), or a home health agency (HHA) in their community. These different levels of post-acute care provide very different levels of medical and rehabilitation care.

We want to take this opportunity to thank you and your staff for engaging PAC stakeholders in developing and refining H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing Act of 2015 and we appreciate the subcommittee’s interest in soliciting comments on the proposed refinements to the bill. The Academy is supportive of the subcommittee’s goal of moving toward a value-based payment care system but only if...
policies emphasize patient care which are based on evidence and sound clinical care practices and outcomes.

The post-acute care sector is in the midst of one of the most active regulatory stages in its history. This regulatory activity accelerated dramatically after enactment of the Improving Medicare Post-Acute Care Transformation Act (“IMPACT Act”) on September 18, 2014. AAPM&R strongly supported passage of the IMPACT Act because we believe that standardized data across the four main settings of post-acute care are critical to appropriately reforming the PAC payment and delivery system in a manner that appropriately determines patient access to the right setting of care at the right time. The underlying premise of the IMPACT Act is that once data is collected and properly analyzed it should drive important policy recommendations.

Given the pace of change in the post-acute care sector, enactment of PAC-VBP programs or reforms at this time would be a tremendous challenge. AAPM&R strongly supports the concept of value-based purchasing for Medicare providers, including post-acute care providers, and expects that the same principles that have driven payment-for-value in many other Medicare provider sectors will eventually be applied to post-acute care. However, it is imperative that VBP for PAC providers is designed correctly and based on reliable data that are standardized across PAC settings. This is critical because without reliable data across PAC settings, there is a serious risk that creating a PAC VBP system, or a unified payment model for PAC providers, will sub-optimize care for the patients we serve.

The hallmark of all PAC reforms must be what is good for patients. Payment and delivery reforms that have the effect of diverting patients to the least common denominator, or the least expensive setting regardless of outcome, rather than the appropriate level of post-acute care to optimize recovery and function, should be rejected. Stinting on patient care is the AAPM&R’s primary concern with all shared savings programs, delivery models, and payment reforms.

The subcommittee presented a series of changes to H.R 3298 and while the green sheet makes an effort to address stakeholder concerns with the bill, AAPM&R wants to take this opportunity to emphasize some key provisions important to our members.

1. **Medicare Spending Per Beneficiary (MSPB):** Medicare Spending Per Beneficiary is an economic measure, a measure that assesses the resource use of a provider or system of care. It does not measure the value the Medicare program is receiving in terms of duration, scope or intensity of health care services provided to patients, nor does it address patient outcomes and quality of care. Use of this
measure as the only method of determining whether PAC providers receive incentive payments will skew incentive payments toward lesser levels of post-acute care (i.e., home health and SNF care) and away from providers who use greater resources to provide their level of care, such as IRFs and LTACHs.

MSPB fails entirely to recognize patient severity, the level or resources provided to meet patient needs, and the functional gains to be achieved through higher intensity, coordinated, interdisciplinary rehabilitation. MSPB has its place in measuring resource use but to designate it as the sole measure for PAC VBP is alarming. We strongly urge the subcommittee to ensure that any PAC VBP bill contains robust and accurate risk adjusters and includes functional and quality of life measures that will distinguish between settings of post-acute care.

2. Need for More Than One Functional Measure: Extensive activity is currently underway on the development, validation, and widespread implementation of PAC measures across multiple settings of care. Many of the measures mandated by the IMPACT Act are process measures (e.g., the percentage or staff or patients provided with influenza vaccine), not outcome measures. The existing measures that are outcomes-driven (i.e., incidence of skin breakdown and urinary tract infections) are basic and make them difficult to use in distinguishing between high quality PAC settings (IRF/SNF) verses low quality settings (IRF/SNF), let alone between different provider types (e.g., between IRFs, SNFs, and HHAs, for instance).

The fact is that outcome measures across the PAC continuum are not yet mature. We simply do not yet have outcome-based measures that answer the most salient questions patients typically have post injury or illness in terms of their recovery and functional potential. Rather than prematurely linking significant payment incentives to an immature set of quality and outcome measures, this subcommittee should allow developments in this area to advance to the point where a PAC VBP would be the next logical step.

3. Timing: We believe passage of H.R. 3298 at this time would add major additional policy changes to a sector that is struggling to comply with the existing pace of reform. Congress should allow the IMPACT Act to be fully implemented before embarking on VBP in the PAC setting.

4. Policy Development: Although value-based purchasing is beginning to take hold in several areas of the Medicare program, the policies applicable to PAC providers must be consensus-based and validated by data from existing VBP programs. Time must be taken to permit the examination of standardized data across PAC settings generated from the IMPACT Act’s requirements as well as more generic
data from other VBP programs outside of post-acute care. We view quality and payment incentive programs as a work in progress and one that we intend to continue engaging in as these policy proposals mature.

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 appreciate your consideration of our comments on key components of the proposed modifications to H.R. 3298 and to engage in this important dialogue. AAPM&R supports VBP PAC reform that places a primary focus on evidenced-based patient care, safety and outcomes across all PAC settings. AAMP&R stands ready to assist the subcommittee as it continues its important work on quality improvement in the area of Medicare post-acute care.

Sincerely,

Greg Worsowicz, M.D., MBA
President
American Academy of Physical Medicine and Rehabilitation