April 7, 2017

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 Chairmen Brady and Tiberi and Representative Kind:

On behalf of the post-acute care (PAC) provider community, the undersigned organizations write to provide our comments on the updated discussion draft of H.R. 3298, the *Medicare Post-Acute Care Value-Based Purchasing Act*, shared in December 2016. Collectively, our organizations represent the entire continuum of the PAC sector. On behalf of our members, PAC providers and patients, we thank you for your leadership on Medicare PAC reform and continue to appreciate the iterative process by which you and your staff are developing this legislation.

In addition to the specific comments below, we want to take the opportunity to express appreciation and recognize some of the positive changes in this most recent draft of the

legislation. Specifically, we believe the following revisions are important to the design of an evidence-based PAC VBP program:

- **Recognizing provider improvement**: The revised discussion draft would recognize both attainment and improvement in evaluating quality and resource use performance.

- **Reinvestment of savings**: Other than the shifting across PAC payment systems, we appreciate the discussion draft's more earnest commitment to budget neutrality by reinvesting all withheld payments in the form of value-based incentive payments.

While we appreciate the numerous substantive changes from the prior version of the bill, we continue to have fundamental concerns with the structure, implementation, and quality measurement underlying the proposed value-based purchasing (VBP) program. Our organizations – collectively and individually – are committed to meaningful Medicare payment reform, including but certainly not limited to VBP. In particular, we think that the new programmatic structure is needlessly complex and leaves far too many of the key details for the Centers for Medicare and Medicaid Services (CMS) to resolve. In assessing provider performance, "value" remains too narrowly focused on cost-containment as marked by the dominance of resource use measures and the elimination of the clinically meaningful quality domain of function. Fundamentally, we feel that assessing value should be built upon the lessons of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and that budget-neutrality must exist not only for the legislation overall, but also *within* each individual payment system of the PAC sector. While we remain committed to advancing incremental payment reform in Medicare, including VBP, we are unable to support the current discussion draft.

As your thinking about payment reform and quality improvement in the PAC progresses, we offer the following principles that we feel would need to be included as part of any PAC VBP program. With the following revisions to the bill, we will be better able to achieve support from our respective memberships.

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

As we noted in our joint letter in September of 2016, the PAC VBP Act places a disproportionate over-emphasis on resource use. While we appreciate your willingness to revisit the measures, still far too much weight is concentrated in the resource use domain, and the Medicare Spending Per Beneficiary (MSPB) measure in particular. In fact, since the prior iteration of the bill, MSPB has actually increased its weight as a total percent of the composite score, in the initial years of the program and in perpetuity. Further, the "geographic measures," as we understand them, are simply the same mandatory measures applied across all PAC providers within a hospital referral region. Thus, the flawed MSPB measure could ultimately account for greater than 60

percent if the Secretary opts to include these measures, and will in essence be counted twice. These geographic measures raise other concerns, discussed below.

As leaders in health care payment policy, you can surely appreciate that value is about much more than cost-containment alone. Value is really a function of outcome per unit of cost. Thus, patient-centered care improvement should be the principal focus of any program designed to enhance the value of health care services delivered. A program truly focused on value—and especially one designed to be budget-neutral—should place *greater* emphasis on quality outcomes than on resource use. As noted, the Hospital VBP program weights resource use far less than quality. And even in that context, the evidence indicates that the inclusion of MSPB is in fact resulting in low-quality hospitals being financially rewarded based on the weight of resource use metrics alone—a problematic result for a program aimed at balancing program costs with patient care. We had previously recommended that resource use be weighted no more than 10 percent of a provider's composite score, and reiterate that recommended scoring weight—particularly as it applies to the more comprehensive measure set in years three and after.

Relatedly, it is imperative that providers not be held accountable for expenditures that are beyond their control within the resource use domain. Because PAC providers are unable to influence "upstream" spending that occurs during an acute care hospitalization, initiation of PAC services should be the trigger of the episode for measurement purposes. We would need to see a directive to CMS along these lines in order to support the legislation.

2. Ensure the VBP program is budget-neutral across and within each PAC subsector.

As we have consistently stated, the PAC VBP program must be budget-neutral within each PAC provider payment system. We perceive that you have heard our concerns regarding the challenge of valuing and aligning provider-specific regulatory relief with potential payment cuts. We thus appreciate the fact that the VBP program has been redesigned to reinvest all savings back into the program in the form of value-based incentive payments. However, we strongly oppose cross-subsidization that could shift resources from one PAC payment system to another. This potential shift is a problem with both the VBP program's scoring methodology and also the inclusion of geographic measures, which compare performance across provider types.

As we have previously stated, evaluating performance across PAC subsectors would be comparing apples to oranges. It is premature to presuppose that the IMPACT Act measures will be able to accurately sort out the intrinsic and critical differences between provider types and that there will not be systemic inherent performance biases, even if unintended, within and across different measures and domains. Without

accounting for the intrinsic and critical differences between the unique cost structures, utilization patterns, and regulatory requirements of each PAC provider type, the PAC VBP programmatic structure itself could impose systemic biases in how it values and measures provider performance, biases which could result in major and unintended consequences. For example, lengths of stay are consistently higher among lower-acuity PAC settings. Conversely, spending per day is consistently higher among higher-acuity PAC settings. These differences hold true across all resource use levels between each provider type and there is no indication these differences are tied to patient outcomes. There is simply no basis to assume that such intrinsic differences could be adequately controlled for in a program that compares resource use across these very different care settings. Our organizations supported the IMPACT Act, which begins the process of establishing linkages across different quality reporting programs, and could support public reporting of the proposed geographic measures. However, we oppose tying payment to performance on geographic measures, which compare across PAC provider type and essentially "double count" the underlying resource use measurement.

Further, we continue to urge that the PAC VBP program be budget-neutral *within* each provider payment system, just like the Hospital VBP program is budget-neutral within the inpatient prospective payment system.

3. Post-acute care payment reform should be based on the most meaningful quality indicators as informed by the evidence

It is imperative that any PAC VBP program center on the measures that are most meaningful to patients. As currently drafted, your legislation would defer to CMS to determine which quality domains, if any, should be included and when. While some administrative discretion is unavoidable to ensure CMS has the flexibility to adapt the program to changing circumstances, our organizations could not support legislation that fails to provide a more definitive blueprint for the quality domains and measures that should be used to evaluate performance.

Not all measures are created equal, and there are clearly certain domains that are an indispensable part of the overall quality picture. For example, function is a key determining factor in whether an individual returns to or remains at home, or will require skilled services to prevent decline, and thus must be a central part of any program designed to incentivize high-quality PAC outcomes. With medical complexity considerations, measuring clinical improvements and stability are important. Identifying and equitably rewarding high-value care related to function must include measures that do not include an "improvement bias" which could unintentionally create access issues, but instead reflect the individual's patient-centered care needs. This necessitates functional measures that reflect outcomes for the achievement of meaningful improvements in cognitive and motor function for beneficiaries with

recovery potential, as well as outcomes for successfully maintaining function or delaying decline in beneficiaries with chronic and progressive conditions.

In general, the PAC VBP measure set should track the quality domains included in the Hospital VBP Program. Implementation of the 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 reliable indicators of quality across settings. So while CMS should not have a completely blank slate to determine which quality domains to include and exclude from the VBP program, the agency should retain the ability to delay implementation until the IMPACT Act measures are shown to be highly indicative of quality and reliable across all PAC settings.

More broadly, the IMPACT Act set forth a timeline to standardize quality measurement in the PAC sector, standardize patient assessment data across different PAC settings, and study and report on modernization of the disparate PAC payment systems. Our organizations supported the IMPACT Act based on this sequential framework and we remain committed to ensuring the process is carried out in accordance with the law's general timeline. We therefore ask that changes be made to the PAC VBP Act so that it adheres to the IMPACT Act's implementation timetable and ensures that requisite cross-setting measures have been fully developed, validated, collected, and vetted before they are cemented into the VBP program.

4. Establish reasonable and fair withhold amounts and simplify the structure of the program.

The PAC VBP program should adopt a reasonable withhold percentage that puts PAC providers on a level playing field with other providers, such as acute care hospitals. The additive approach of considering a range of distinct Medicare initiatives to justify the bill's higher withhold percentages is unworkable and unfair, and the bill should instead ensure parity *across* the VBP programs specifically. Moreover, because this program would not replace other initiatives with payment withholds, some PAC subsectors could be subject to an annual withhold of 10 percent or greater. Simply put, that is neither fair nor sustainable. While we appreciate the Committee's movement from prior drafts, we simply cannot support a VBP program that withholds 5 percent of Medicare payments. As previously stated, we support a withhold of 2 percent, consistent with the Acute Care Hospital VBP program's withhold.

In addition, we believe the two-track performance-risk system is needlessly complex and completely lacks any sound evidentiary basis. Although we appreciate the intention to consider the compounded effect of participating in multiple initiatives, it is simply too convoluted to assign providers to different risk tracks with different

withhold amounts in each year. This framework is admittedly difficult for our organizations (with considerable policy expertise) to follow, and we feel it would be unreasonably burdensome for the average PAC provider to try to disentangle and understand, much less adjust to the financial impact year-over-year. This is especially the case for those PAC subsectors that would have to simultaneously participate in multiple VBP programs. While we all share the goal of "regulatory relief," we cannot support it at the expense of considerable newfound regulatory complexity.

Moreover, we do not believe that the criteria used to differentiate between the high- and low-risk tracks are intuitive or appropriate. For one thing, the list of initiatives that qualify a provider for the low-risk track is a hodgepodge of mandatory and voluntary and temporary and permanent programs that each carry different trajectories and prospects in the future. Some of them tie up a considerable percentage of Medicare payments while others do not. This would result in PAC providers on the same risk track having highly variable proportions of their overall payment "as risk."

In general, we do not think it makes sense for these tracks to be permanently tied in statute to participation in potentially fleeting programs like the Comprehensive Care for Joint Replacement (CJR) or the Bundled Payments for Care Improvement (BPCI) initiatives. As you know, the CJR in particular faces staunch opposition both in Congress and with the new Secretary of HHS. Moreover, the participation of PAC providers in the CJR is not necessarily transparent since the program is designed around two discrete acute care diagnostic related groups (DRGs) within the area of lower extremity joint replacements. Other alternative payment models, such as accountable care organizations, may be a more meaningful indicator of PAC providers' engagement in downside risk payment. We simply do not know which initiatives will be in force during the proposed duration of the two-track risk framework from FY 2020 to FY 2026.

Although there is presumably a way to replace these specifically identified initiatives with more permanent criteria regarding downside risk, we view this two-track risk framework as needlessly complicated and potentially unworkable. Instead, we encourage you to utilize a single risk track with the withhold amounts currently assigned to the low-risk track, and to eliminate the competing VBP programs, as prior versions of the bill would have done.

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We appreciate your consideration of our suggested further changes to the PAC VBP Act. Although considerable differences remain, we are committed to working with the Committee and hopeful about the opportunity to find common ground on this important issue. More than ever, the PAC provider community supports the concept of a fairly designed, evidence-based

value-based payment design and respectfully requests the Committee address our remaining concerns.

Sincerely,

American Health Care Association
American Medical Rehabilitation Providers Association
American Academy of Physical Medicine & Rehabilitation
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

cc: Members of the House Committee on Ways and Means