

September 20, 2016

The Honorable Kevin Brady
U.S. House of Representatives
301 Cannon House Office Building
Washington, DC 20515

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

Dear Representatives Brady and Kind:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations – including more than 3,300 institutionally based or affiliated providers of acute long-term care, inpatient rehabilitation facilities, hospitals with skilled nursing and extended care beds, and hospital-based or -affiliated home health agencies – the American Hospital Association (AHA) writes to share our continued concerns regarding H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015. While we appreciate the committee’s willingness to make changes to this proposal based on stakeholder feedback, we believe the current changes do not go far enough to address the underlying problems with the legislation.

The AHA supports the concept of VBP programs that tie provider payment to performance. When appropriately designed, VBP approaches can support the transition from volume to value that already is underway in the health care field. Congress passed the Improving Medicare Post-Acute Care Transformation (IMPACT) Act in 2014 to expand the reporting requirements for post-acute care. The collection of this information is intended to build a common data reporting infrastructure for PAC providers in order to align quality measurement across PAC settings and to inform future payment reform efforts. The information that will be collected due to the IMPACT Act will be vital to the creation of any PAC VBP program. Until we have access to reliable, well validated data from the IMPACT Act, moving forward with a PAC VBP program would be premature.

In addition, the current design of the PAC VBP program is too narrowly focused on cutting provider payment rather than promoting “value” – that is, the delivery of consistently high-quality care at a lower cost. The PAC VBP program established in this legislation would withhold 5.0 percent of PAC payments in fiscal year (FY) 2020 and beyond. Regrettably, 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 strongly opposes utilizing VBP to achieve reductions in the Medicare program; this proposal must be budget neutral overall and within each PAC payment system. The AHA also is very concerned that the PAC VBP program’s payment withhold is too high, and is out of step with other Medicare VBP programs. The acute care 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. Any PAC VBP program should have a payment withhold amount that is consistent with these VBP programs and be developed around a multi-year transition period toward that withhold.



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AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. However, by using only the Medicare Spending per Beneficiary (MSPB) and functional status measures, the PAC VBP program appears focused on only the cost side of the value equation. This is especially true because MSPB would be the only measure used to evaluate performance in the first two years of the PAC VBP program. Without a more balanced, budget-neutral approach that includes a broader set of valid, reliable quality measures, the PAC VBP program appears to function as a mechanism to reduce overall provider payments in perpetuity, rather than 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 its control. In the first two years of the program, 55 percent of a provider's VBP performance score would be tied to its own performance on the MSPB measure, while 45 percent would be tied to the performance of all other PAC providers in the Hospital Referral Area. This approach would not only fail to encourage collaboration across providers, but may lead to unfair performance comparisons. Because there are differences in the mix of PAC services across regions and different MSPB measures have been developed for each type of PAC provider, a particular PAC provider's MSPB performance determination should not be determined by data derived from any other PAC provider, regardless of type. For example, an inpatient rehabilitation facility's (IRF) MSPB performance determination should be formulated only with data derived from its performance on the IRF MSPB measure, and a long-term care hospital's (LTCH) MSPB performance determination should be formulated only with data derived from its performance on the LTCH MSPB measure.

Finally, PAC providers have faced numerous regulatory and statutory payment reductions and restrictions in recent years – such as site-neutral payment for LTCHs, and the “60 Percent Rule” for IRFs, to name just a few. PAC providers also already 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. Given the magnitude of these requirements, now is not the time for a flawed PAC VBP program.

Thank you for your consideration of these important issues. Please contact me if you have questions or feel free to have a member of your team contact Aimee Kuhlman, AHA senior associate director of federal relations, at akuhlman@aha.org or (202) 626-2291.

Sincerely,

//s//

Thomas P. Nickels
Executive Vice President