American Hospital Association

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October 6, 2015

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1135 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Representative 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 concerns regarding H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015. The AHA continues to support the concept of VBP programs that tie provider payment to performance. However, as currently designed, 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 legislation would repeal the fiscal year (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. The PAC VBP program would withhold 3.0 percent of post-acute care payments in FY 2020, rising to 8.0 percent in FY 2025 and beyond. Individual providers could earn back some or all of the withheld funds – and potentially earn a bonus – based on their performance on only one measure – Medicare spending per beneficiary (MSPB). 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 strongly opposes utilizing VBP to achieve reductions in the Medicare program; the program should be budget neutral.

AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. However, by using only the MSPB measure, the PAC VBP program appears focused on only the cost side of the value equation. The AHA believes pay-for-performance programs should include both cost *and* quality measures to ensure that the reward system encourages both high quality and lower costs. 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. As currently designed, 55 percent of a provider's VBP performance score would be tied to their own performance on the MSPB measure, while 45 percent would be tied to the performance of all other post-acute care providers in the Hospital Service Area where the provider is located. 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.

Lastly, the AHA is very concerned that the PAC VBP program's payment withhold is too high, and is out of step with 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 have faced 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.

Thank you for your consideration of these important issues. If you have any questions, please contact me or Aimee Kuhlman, AHA senior associate director of federal relations, at akuhlman@aha.org.

Sincerely,

//s//

Thomas P. Nickels
Executive Vice President