

THE EVOLUTION OF QUALITY IN MEDICARE PART A

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

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THE EVOLUTION OF QUALITY IN MEDICARE PART A

WEDNESDAY, SEPTEMBER 7, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:04 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, August 31, 2016
No. HL-10

CONTACT: (202) 225-3943

Chairman Tiberi Announces Hearing on Incentivizing Quality Outcomes in Medicare Part A

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH) announced today that the Subcommittee will hold a hearing entitled “The Evolution of Quality in Medicare Part A.” **The hearing will take place on Wednesday, September 7, 2016, in Room 1100 of the Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, September 21, 2016.** For questions, or if you encounter technical problems, please call (202) 225-3943.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available online at: <http://www.waysandmeans.house.gov/>.

Chairman TIBERI. The Subcommittee will come to order.

Welcome to the Ways and Means Subcommittee on Health hearing on the evolution of quality in Medicare Part A.

In mid-May, you may remember our Health Subcommittee held a hearing on the implementation of the Medicare and CHIP Reauthorization Act, or MACRA, of 2015. Today's hearing follows along the same theme used in that hearing.

Once a major quality program has been operating for a few years in Medicare, we review the implementation and discuss lessons learned. During today's hearing, we will review the status of quality programs in place for Medicare Part A.

The first item on our agenda is to review the many quality and pay-for-performance programs that are in place for hospitals. In addition to reporting quality measures, hospitals are also on the hook for readmission and hospital-acquired-condition penalties as well as value-based purchasing programs. As you will hear from our witnesses today, a total of 8 percent is at risk for quality performance for hospitals.

As we apply the lessons learned from hospital quality programs, we will explore how we should legislate within the post-acute care space. As we will hear from the witnesses today, post-acute care is lagging a bit behind where hospitals currently are. We will hear about the important changes that were made in the bipartisan, bicameral IMPACT Act of 2014, and we will hear directly from stakeholders on IMPACT's implementation.

Part of IMPACT's story has already been told, as three of seven quality measures for IMPACT have already been implemented. Some of the IMPACT stories will be told over the next 2 years as CMS continues to implement the four remaining measures.

But just because the IMPACT story is ongoing does not mean Congress should idly sit by and wait. Over the next few weeks, the Committee will debate and deliberate over the most effective ways to incentivize high-quality, low-cost care. Whether it is H.R. 3298, the PAC VBP bill introduced by Chairman Brady and Mr. Kind, or other ideas our Members have to offer, this Committee will explore these ideas further.

The last thing we will address in today's hearing is how we can look to reduce the regulatory burden for hospital and PAC providers. Our witnesses will highlight the many regulatory challenges that providers face in the Medicare program. These regulatory challenges are real, and they distract from ultimate patient care. Therefore, we need to have a serious discussion about these

challenges. Such discussions will likely result in real costs to the Medicare program, but it is our goal to provide relief and pay for that relief through consensus-based quality payment reforms.

Again, we are all here for the same reasons today, as I have stated in the past: To explore ways to better improve the quality of care for our Medicare patients.

I now would like to yield to our distinguished and retiring Ranking Member, Mr. McDermott, for an opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I notice you mentioned my retirement. That means you are going to get rid of me, right? I am sure that isn't what you meant.

This is the kind of hearing where there isn't much disagreement about the fact that we want to have quality. I mean, we are all here for that. And promoting quality is critical to the millions of beneficiaries that receive care in hospitals and nursing homes and hospices and other settings covered under Part A. And I am hopeful we can have a constructive discussion about this.

We have made some substantive bipartisan progress recently. We need to build on our success. Last year, we came together with MACRA. That landmark reform repealed the SGR and already started the process of transforming how we try to pay physicians under Medicare.

And in the Part A space, we have begun to lay the groundwork for payment reform by passing the IMPACT Act, which will give us the data we need to improve quality in post-acute care settings. These are significant bipartisan achievements that will help us continue to move forward toward a value-based system that rewards efficient and high-quality care. It will make Medicare stronger and save billions of dollars, but improving quality is not just about reducing costs. It is also about improving outcomes in ways that have real consequences for patients.

We face a crisis that this Committee rarely discusses. Every year, between 210,000 and 440,000 Americans die in the hospital setting due to preventable medical error, including 180,000 Medicare beneficiaries in 2010 alone. If that was happening in the airline industry, we would have an uproar in this Congress, but in this setting somehow it doesn't get discussed. Preventable medical errors are now the third-leading cause of death in this country.

Now, we must recognize that achieving value isn't all about cutting costs; it is also about helping patients and saving lives. Payment reforms that put patients first and incorporate sound quality improvement measures are an important part of how we can address this problem.

Unfortunately, my colleagues are not always in agreement with us on this issue. The Hospital Readmissions Reduction Program, for example, cut the number of hospital readmissions by 565,000 between 2010 and 2015. Likewise, the Hospital-Acquired Condition Reduction Program has saved Medicare \$19.8 billion and, more importantly, prevented the death of some 87,000 people. Yet every Republican here today has called for the repeal of the Affordable Care Act, including these lifesaving initiatives that are already improving the quality of health care provided by the hospitals.

Now, I take the Chairman's call here today as an acknowledgment that we are going to stop trying to repeal it and try to make it better. That is really what we all want to do.

Similarly, the Center for Medicare and Medicaid Innovation is testing exciting new payment models that will provide us a path to move forward in the healthcare system. The data and evidence that the Innovation Center is gathering will be critical to informing our conversation about delivery system reform. Yet the Speaker, the former Chairman of the Ways and Means Committee, has proposed a Republican agenda that singles out this program for elimination. Why would you single out a program of innovation as a way forward in health care?

If we are having a serious conversation about the evolution of quality in Medicare Part A and if we are serious about addressing these issues in a bipartisan way, my colleagues on the other side need to recognize what is happening right before their eyes. We have programs that are there because of the ACA that are, in fact, doing what we want: Providing better care.

Quality in Part A is already evolving, and it is thanks to the Affordable Care Act. No one can put a social insurance program together and anticipate all of what is going to happen. None of us on our side who were involved in drawing it up thought for one minute that we had created the Ten Commandments off the mountain, which haven't been changed since Moses brought them down off the mountain. The Affordable Care Act needs some changes, needs some things added to it, and I think that is what this hearing really should be about.

And I am glad you are having this hearing, Mr. Chairman.

Chairman TIBERI. Thank you, Mr. McDermott.

Mr. MCDERMOTT. I yield the rest of my time.

Chairman TIBERI. Thank you. I think I will just say thank you. You almost got me to engage with you, but I think I will just refer now to our Chairman, the distinguished gentleman from Texas.

Thank you for being here, sir.

Chairman BRADY. Well, thank you, Chairman Tiberi, for your patience and for holding this important hearing.

Thanks to all our witnesses for being here.

I am really here to underscore the importance of Chairman Tiberi's bipartisan drive toward quality in Medicare. This hearing is a remarkable opportunity to examine how existing Medicare policies are incentivizing hospitals and post-hospital providers to deliver high-quality, cost-efficient care.

This is a critically important issue for several reasons. First, it is key to our efforts to preserve Medicare for the long term. By incentivizing quality over quantity, we can improve care. We can reduce duplication and waste and bring down the costs to the program, which makes it solvent for the longer term.

Second, perhaps more importantly, Medicare payment policy can significantly impact the ability of seniors and others in Medicare to access the high-quality care they need and they deserve.

Last year, Congress passed landmark legislation, which has now become law, to reform and modernize the way Medicare pays physicians. The bill puts emphasis on quality rather than quantity, a

policy shift that will make a real difference in the lives of Medicare beneficiaries.

But physician payment policies are just one piece of the puzzle. To ensure the Medicare program is truly delivering the high-quality care seniors deserve, we also need to improve the way it pays post-acute or after-hospitalization providers. And we need to take the same value-based approach, rewarding providers for how well they serve Medicare patients, not how often they serve Medicare patients.

Last July, I introduced bipartisan legislation with Congressman Kind on this Committee to help accomplish this important goal. Our bill, the Medicare Post-Acute Care Value-Based Purchasing Act, takes meaningful steps to strengthen Medicare for the long term and improve access to high-quality care for current and future Medicare beneficiaries.

By providing the right incentives, this legislation will bring increased competition and innovation to Medicare while lowering costs to the program. At the same time, the bill will raise the bar for patient care nationwide. It rewards providers who set themselves apart in delivering excellent care to Medicare patients.

Today's hearing is a critical first step in advancing patient-focused solutions like this one, solutions that build on our past successes in payment reform to improve Medicare for all Medicare patients.

Again, thank you to Chairman Tiberi for his leadership in this effort. Thank you to the Committee Members, who take progress and quality and innovation in Medicare seriously, diving into these issues and looking for bipartisan solutions to move forward.

So, with that, I yield back to Chairman Tiberi and thank you again for your leadership.

Chairman TIBERI. Thank you, Chairman Brady.

Without objection, other Members' opening statements will be made part of the record.

We are joined by four individuals today.

First, we will hear from Barbara Gage, an Associate Research Professor from George Washington University.

Next, Elisabeth Wynn, the Senior Vice President of Health Economics and Finance at the Greater New York Hospital Association. Thanks for being here.

After Elisabeth, we will hear from Steven Guenther, the President of Almost Family.

And, finally, we will hear from Gregory Worsowicz, the President of the American Academy of Physical Medicine and Rehabilitation.

Each of you will be recognized for 5 minutes. Your full testimony will be made part of the record.

With that, Ms. Gage, you are recognized for 5 minutes. Thank you.

STATEMENT OF BARBARA GAGE, PH.D., MPA, ASSOCIATE RESEARCH PROFESSOR, GEORGE WASHINGTON UNIVERSITY, CENTER FOR HEALTHCARE INNOVATION AND POLICY RESEARCH, SCHOOL OF MEDICINE AND HEALTH SCIENCES, WASHINGTON, D.C.

Ms. GAGE. Thank you very much for the invitation to speak today and good afternoon, Chairman Tiberi and Ranking Member McDermott and the other esteemed Members of the Subcommittee. Thank you for the opportunity to testify on incentivizing quality outcomes in Medicare Part A.

As mentioned, I am a health services researcher, and I have been working in these areas for many years. I have led a lot of the Federal national studies for the Centers for Medicare and Medicaid Services, looking at post-acute care payments and quality reform over the last 20 years, and I would like to leave you with four important points today.

One is that one in five beneficiaries are hospitalized each year, and, out of them, about 40 percent go on to use post-acute care. So when somebody is hospitalized in the Medicare program, they are using a lot of services. And there is actually an exhibit at the back of your testimony that shows some of the ping-ponging patterns that go on.

Two, passage of the IMPACT Act a couple years ago was one of the most important pieces of legislation. As patients go in and out of these skilled nursing facilities, rehab hospitals, long-term care hospitals, and home health agencies, they are each getting medical services and rehab services to some lesser or greater degree, but we didn't have a consistent way to measure how complex they were, and the IMPACT Act has given us the tools to do that.

Although, one group that was omitted when we think about beneficiary episodes of care were the hospitals, which is where the episode of care begins and where the communication about that patient's trajectory really ought to begin.

The third key point that I would make is that in the subsequent legislation that has tied quality to payment you have really seen some changes occurring.

So, with that said, I am going to turn to my written testimony. The first part I will skip over, just to make the point that 40 percent of those people who are hospitalized were discharged to one of several additional providers for continuing medical or physical rehabilitation treatments during their episode of care. That was in 2008. More recent numbers by MedPAC have it at 45 percent. So, as our population ages, they are getting more complex. And it underscores the importance of the episode of care and not the silo of care in which they are treated.

One of the most important directives that started a lot of this was the DRA of 2005. The Deficit Reduction Act called for standardized assessment so we could really see to what extent that stroke patient was being discharged from the hospital to a skilled nursing facility versus the hospital to the rehab hospital. If the patients were very different, then that called for different resources, and we might expect different outcomes, but we didn't know that without having standard ways of measuring them. So the DRA led the science to develop those elements based on the consensus and

the input of the various clinical communities, the real experts in treating patients.

In 2014, when you passed the IMPACT Act, it gave CMS the impetus to move the standardized elements into the existing assessment tools that are used in each of the four settings and laid the foundation for the quality reporting programs to be more comparable. But we still have four quality reporting programs, and we don't know how complex the patient was at discharge.

Just for a little background about these post-acute care providers: Long-term care hospitals, while they are admitting 2 percent of those post-acute users, most patients have been in an ICU at least 3 days prior to the admission. The rehab hospital, they are cases that have high needs for physical medicine and rehab, and I think Dr. Worsowicz will speak to that. SNFs are important for that medical care but not that high-level acute care. And home health is one of the backbones of our delivery system.

So I am currently co-directing a contract with the RAND Corporation to implement the rest of the IMPACT Act, and this work is very important. It is one of multiple contracts that CMS has underway to be measuring, to be designing consistent quality metrics. Those metrics are key to setting up value-based purchasing programs or accountable care organizations. Whatever framework you want to put that value into the payment system, you need to understand the impact on the outcome, and the IMPACT Act gave us the foundation to allow that to occur.

So I guess my big take-home point is that tying payments to minimum quality thresholds to ensure that services are appropriate and cost-effective is key to effectively redesigning the Medicare program in a way that ensures beneficiaries have access to the appropriate services they need.

The various quality reporting programs and value-based purchasing programs have moved the dial forward, but you are still operating in silos. And moving forward so that you are looking at a patient's episode of care and not the setting to which they admitted will be even more impactful when tying outcomes to patients.

These are complex issues, and I am happy to take any questions that you may have.

[The prepared statement of Ms. Gage follows:]



George Washington University
School of Medicine and Health Science
Barbara Gage, Ph.D., MPA

The Evolution of Quality in Medicare Part A

Testimony before the U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

Statement of
Barbara Gage, Ph.D., MPA
Associate Research Professor
George Washington University
Center for Healthcare Innovation and Policy Research
School of Medicine and Health Sciences

September 7, 2016



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Barbara Gage, Ph.D., MPA

Good afternoon, Chairman Tiberi, Ranking Member McDermott, and distinguished members of the Subcommittee. Thank you for the opportunity to testify today on Incentivizing Quality Outcomes in Medicare Part A. I am a Health Services Researcher and Associate Professor at George Washington University. Over the years, I have been fortunate to lead many of the Federal studies of Post-Acute Care Payment Reforms and Quality Measurement initiatives funded by the Centers for Medicare & Medicaid Services. These studies have laid the groundwork for understanding the health care utilization trajectories common for the one in five Medicare beneficiaries who are hospitalized each year.

My early work showed that almost 40 percent of all hospitalized beneficiaries were discharged to one of several additional providers, or post-acute providers, for continuing medical or physical rehabilitation treatments during their episode of care. Subsequent work by the Medicare Payment Advisory Commission (MedPAC) shows that number continues to grow. Exhibit 1 shows the national care trajectories in 2008 – following hospital discharge, 37 percent were discharged to home health agencies (HHA), 42 percent were admitted to skilled nursing facilities (SNF); 8.6 percent went to inpatient rehabilitation facilities (IRFs) or hospitals, 1.7 percent to long term care hospitals (LTCH), and another 10 percent to community-based therapy services, either in outpatient hospital settings or other Part B covered therapy offices. About 20 percent of the PAC users were readmitted to the hospital within 60 days of having left the hospital (Gage et al, 2012). More importantly, a substantial number of the PAC patients used multiple PAC services during their episode of care. This work laid the foundation for many of the subsequent initiatives to improve the coordination of care and reduce the costs of the



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Medicare program by creating patient-centered initiatives that could hold entities accountable for an entire episode of care, whether it was via medical homes, accountable care organizations, bundled payments, or other efforts to reach the Triple Aim by improving the quality of care, and thereby, reducing costs in the Medicare program.

Congress has passed some very important legislation over the past 10-15 years to move away from policies that focus on the individual silos of care, and instead, create accountable entities to manage a patient's entire episode of care. When Congress passed the Deficit Reduction Act (DRA) of 2005, one directive was to re-align the different parts of the post-hospital service system to improve the management of patient costs and outcomes across an episode of care. It was obvious from related research that patients admitted to the hospital for the same treatment were being discharged to different types of post-acute care settings, depending on the availability of beds and other factors (Gage et al, 2009).

One of the most important directives in the DRA was the development of standardized assessment items to enable consistent measurement of a person's medical status, functional status, cognitive status, and social support system factors regardless of which type of PAC setting the patient used during their episode of care. Under a CMS contract with RTI where I directed their post-acute research program, my team and I worked with clinicians across the country in acute hospitals and each of the four PAC settings to identify the "best" approach for measuring medical, functional, and cognitive status of a patient, regardless of complexity so the patient's severity could be consistently measured and monitored for improvement across an



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episode of care. More importantly, standardized data would allow Congress and the Medicare Payment Advisory Commission (MedPAC), to determine whether the Medicare program was paying different rates for the “same” patient treated in alternative PAC settings. The standardized elements were tested for psychometric performance to ensure that only statistically valid and reliable items were considered in subsequent payment and outcomes modeling, including the analysis submitted by the MedPAC this past June in their 2016 Report to Congress on unified PAC payment or case-mix approaches.

In 2014, Congress passed the IMPACT Act which is enabling CMS to implement the standardized data elements in the Federally-required PAC assessment tools so that beneficiary severity of illness can be measured consistently across settings. At this time, many of the standardized elements tested in the Post-Acute Care Payment Reform Demonstration (PAC PRD) are being incorporated into CMS’ four individual quality reporting programs (QRP) for PAC. Currently, the LTCH QRP monitors the outcomes of the small number of highly complex patients discharged to LTCHs following at least 3 days in the intensive care unit at the short stay hospital, many with severe infections affecting their respiratory or integumentary areas. The standardized items are being used to adjust for patient severity differences while monitoring LTCH outcomes.

Similarly, the IRF QRP monitors the outcomes for patients discharged to IRFs following short stay hospital treatments for injuries and conditions, such as brain injury, spinal cord injury, neurological conditions such as strokes, Parkinson's Disease, or Multiple Sclerosis, or major



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multiple traumas, amputations and other acute conditions. The standardized items are also being incorporated into the assessment tools used to monitor the outcomes of the substantial number of beneficiaries discharged from hospitals to SNFs following hip replacements or treatments for pneumonia or other medical complications following surgery. Home health assessment tools also fall under the IMPACT Act requirements so that regardless of where a patient goes following hospital discharge, the quality of the services and the outcomes associated with care can be consistently measured.

Standardizing the commonly used assessment concepts allows comparison of the severity of patients admitted to different PAC settings as well as comparison of the outcomes, given the potential substitution of PAC settings for continued medical and functional treatment. While some substitution is occurring, the PAC providers also treat significantly different populations whose care cannot be addressed in lower level PAC settings. The standardized assessment items allow for identifying these more complex cases that require the higher intensity, higher cost services provided in the acute-level PAC settings.

One provider that is missing from this effort to consistently measure a patient's acuity across the entire episode of care is the short stay acute hospital. While hospitals were originally included in the IMPACT Act, they were not included in the final legislation. Instead, they were given directives in their conditions of participation to include the type of information PAC providers submit in their discharge summaries but no direction to use the standardized items PACs must submit. However, the episode begins at the short stay hospital and in order to ensure



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that hospital patients are discharged to the appropriate setting, it is critically important to understand the medical, functional, and cognitive complexity of the patient before discharging them to the next level of care, a concern that has been underscored since in both research and by the four PAC provider communities. The standardized data are also the foundation for creating exchangeable information when transferring the patient so the PAC provider receives accurate and timely information about the patient when they are admitted for continuing treatment.

I am currently co-directing a CMS contract with the RAND Corporation to further implement the IMPACT Act by testing additional data elements for PAC providers that may be important for monitoring quality and outcomes across settings. Unlike the PAC PRD which tested the reliability of the proposed elements in the acute hospital and PAC settings, the goal of this work is to complement the work underway for the four respective PAC QRP to ensure that future elements are also reliable and valid when applied in more than one type of setting. Additional work under the IMPACT Act is underway to develop standardized quality metrics for use across the PAC settings. This work is important because hospitals now have numerous incentives under the value-based purchasing programs, the ACOs, and other initiatives to manage the costs of an episode and seek the lowest cost setting for delivering the PAC medical and functional treatments. While this has been a very effective use of market incentives to direct more efficient care, the value or impact of these incentives needs to be carefully monitored. The science of quality measurement has grown extensively over the past 10 years and provides a useful tool for ensuring beneficiaries have access to the high value care expected under the Medicare program.



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These past few years we have seen many advances in incentivizing providers to deliver high-quality, cost-efficient care. Readmission rates during later parts of an episode have been dramatically reduced with many taking responsibility for the gains – the Accountable Care Organizations, the Bundled Payments for Care Improvements (BPCI) participants, the Medical Homes, the Value-Based Purchasing programs. Each have contributed by responding to the payment incentives to reach beyond their discharge door and manage the patient costs across the episode. CMS has been expanding these initiatives more recently with the Comprehensive Care for Joint Replacement and the Alternative Payment Models for Oncology but these efforts are limited to certain groups of patients. Medicare beneficiaries who are discharged to PAC tend to have multiple conditions underlying their declining health. Expanding these efforts to other types of PAC populations can further provide hospitals the incentive to provide high performing systems of care. Providers respond to financial incentives. Until financial incentives were tied to the readmission rates and other quality incentives, providers were slow to respond to the quality requirements. Tying payments to minimum quality thresholds to ensure that services are appropriate *and* cost-effective is key to effectively redesigning the Medicare program and not creating access barriers for the most vulnerable Medicare beneficiaries.

As you consider future directions, you now have the science and the tools to not only manage the costs of care as we have done for years in managed care plans, but also to manage the quality of care as the clinical communities reach consensus on standardized terminology to describe the complexity of the patients they treat, and the changes in patient complexity. This scientific gain allows you to tie outcomes into payments with a reassurance that realistic



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expectations are being set. Not all beneficiaries will return to a prior state of health, but given the standardized assessment elements called for in the IMPACT Act, we can risk-adjust outcomes in a standard way that will recognize the differences in complexity of the hospital patient discharged to an LTCH, IRF, SNF, or HH. And by incorporating those differences into expected outcomes metrics through risk-adjustment, we can define value by setting realistic expectations for average outcomes given a hospital discharge to an IRF compared to a SNF. Patients who have suffered a stroke, for example, may be discharged to either of the two PAC settings for rehabilitation therapy; however, depending on their complexity, their outcomes may differ significantly (Gage, et al, 2012). And identifying their complexity at time of hospital discharge would level the playing field to ensure the “same” patient is really being sent to lower cost PAC options when differences in outcomes are found. And using consistent quality metrics will allow the PAC providers to prove the value of their relative services.

The IMPACT Act set the platform for measuring value by standardizing language based on the clinical communities’ expertise. The various QRPs and VBPs have moved the dial forward by giving providers the incentives to provide high-quality care within their various silos. You now have the tools to move the science forward and create high value, high performing systems of care for even the highest cost, most vulnerable beneficiaries – those discharged to PAC following hospital treatments.

These are complex issues. The healthcare markets are undergoing dramatic change in both the private and public payer programs. The redesign efforts are driving providers to be more



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accountable for the patients they treat and not just the care they provide inside their doors. The opportunity to improve care, increase efficiencies without putting beneficiary access at risk, and improve the value of the healthcare provided under Medicare is tremendous.

Thank you for the invitation to speak today. I am happy to take any questions and can also be reached at my office at the George Washington University (bgage@gwu.edu).

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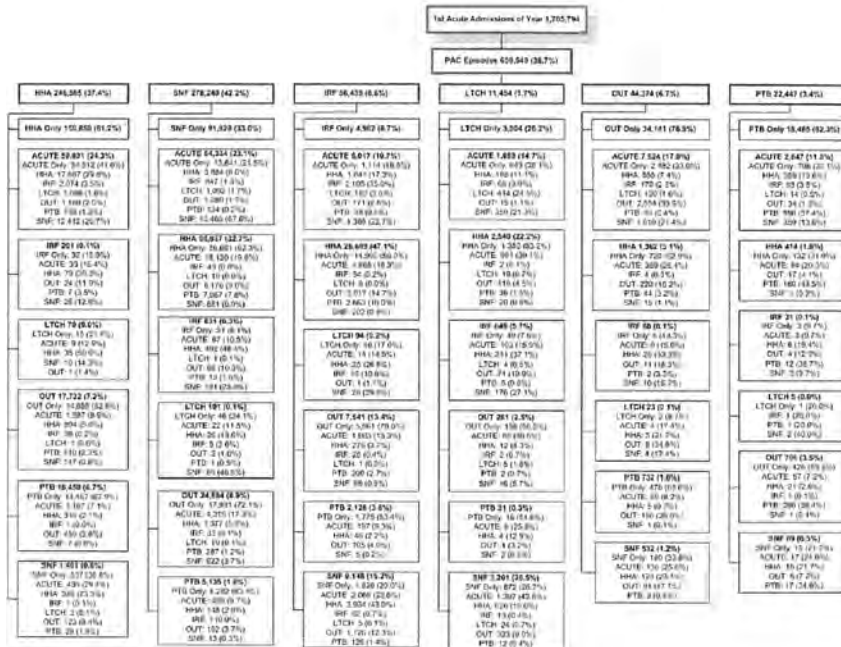
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Exhibit 1:
Medicare Post-Acute Care Transitions Following Acute Hospital Discharge, 2008



Source: Post-Acute Care Payment Reform Demonstration Final Report, B. Gage, et al., March 2012,
CMS Contract No. HHSM-500-2005-000291

Chairman TIBERI. Thank you.

Ms. Wynn, you are recognized for 5 minutes.

**STATEMENT OF ELISABETH WYNN, SENIOR VICE PRESIDENT,
HEALTH ECONOMICS AND FINANCE, GREATER NEW YORK
HOSPITAL ASSOCIATION, NEW YORK, NEW YORK**

Ms. WYNN. Great. Thank you.

Good afternoon, Subcommittee Chairman Tiberi, Ranking Member McDermott, and other distinguished Members of the Committee. I am Elisabeth Wynn with the Greater New York Hospital Association. We represent about 150 hospitals across New York, New Jersey, Connecticut, and Rhode Island. Most are teaching and/or safety net hospitals, meaning that they serve a high proportion of low-income patients.

Greater New York greatly appreciates the opportunity to testify regarding Medicare's pay-for-performance programs, colloquially known as P4P. As providers work collaboratively to implement alternative payment models, such as bundled payments, it is imperative that the financial incentives to improve quality and efficiency are aligned across the provider sectors.

Successful adoption of these alternative pay models may be the only viable option for hospitals with a high Medicare and Medicaid patient population to keep their doors open, because of the underpayments from these programs. Therefore, we applaud the Committee for taking up these very important topics.

The Medicare P4P programs have appreciably advanced hospitals' focus on patient safety initiatives and outcomes. Every hospital now has a dedicated effort to prevent infections, reduce readmissions, and improve patient satisfaction scores. Greater New York supports these efforts through our innovative quality collaboratives, such as reducing readmissions between member hospitals and local nursing homes. We are very proud of the quality improvements that our members have made through these efforts, although we all recognize that there is still a lot of work to be done.

This afternoon, I want to touch on the financial impact of the P4P programs on our hospitals, our concerns with some of the technical aspects of the programs, and opportunities for Congress to improve upon the current framework.

Hospitals are currently evaluated in five different P4P programs, which evaluate hospitals on quality reporting and performance on measures such as 30-day mortality rates for heart failure, 30-day readmissions for knee replacements, or complication rates from infections such as sepsis or pressure ulcers.

Combined, these programs result in an aggregate savings to the Medicare program of nearly \$1 billion or 1.1 percent of hospital payments. Nearly 60 percent of these savings, or over \$500 million, is generated from the readmissions program, and 40 percent, or nearly \$400 million, is generated from the complications program, known as HAC. Value-based purchasing, or VBP, is budget-neutral to the Medicare program, although it is redistributive among hospitals.

At the hospital level, the penalties top out at roughly 6 percent of payments, but the impact varies by type of hospital. For example, major teaching hospitals incur the largest penalties, at about

1.7 percent of their Medicare payments, followed by high safety net hospitals treating low-income populations, at about 1.2 percent. The higher impact for these groups is due to the disproportionate losses that they suffer from the readmissions and HAC programs.

The key finding from our analytical work on these issues is that some of the P4P programs unfairly penalize hospitals for factors beyond their control.

First, as recognized by this Committee in the Helping Hospitals Improve Patient Care Act, the readmissions rates are not risk-adjusted for patients' socioeconomic status or patient risk factors that are beyond the control of the hospital. We applaud the Committee for this work on this issue and call on the Senate to adopt similar legislation.

Also, the readmission program penalizes hospitals for their 30-day readmission rates, a timeframe that really is more a reflection of what occurs in the community post-discharge as opposed to the care that is occurring within the hospital.

In the VBP program, 25 percent of the hospital's performance score is based on their patient satisfaction score. Hospitals treating higher percentages of low-income patients are more likely to perform poorly on these measures because they don't have the financial resources to invest in building amenities, like single-patient rooms or modifications to reduce noise.

Another key design problem is that the readmission and HAC programs fail to recognize hospital improvements, so hospitals can continue to incur significant financial penalties even as the rates of these events decline. A full 25 percent of hospitals are always penalized by the HAC program.

Having five different P4P programs also provides an unnecessary level of complexity that is difficult for the average hospital to understand. We strongly encourage you to adopt reforms that consolidate the hospital P4P programs, similar to the approach adopted for physicians, to streamline the programs, balance the incentives, and improve the fairness.

Thank you for the opportunity to testify, and I look forward to your questions.

[The prepared statement of Ms. Wynn follows:]

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555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-1100 • F (212) 362-4340 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. NASKE

Testimony of the Greater New York Hospital Association Before the Ways & Means Subcommittee on Health

Hearing on Incentivizing Quality Outcomes in Medicare Part A

September 7, 2016

Good afternoon Subcommittee Chairman Tiberi and other distinguished members of the Committee. I am Elisabeth Wynn, Senior Vice President of Health Economics & Finance at the Greater New York Hospital Association (GNYHA). On behalf of our nearly 150 hospitals and health system members in New York, New Jersey, Connecticut and Rhode Island, GNYHA greatly appreciates the opportunity to testify about Medicare's hospital value-based purchasing (VBP) and other inpatient pay-for-performance (P4P) programs. We commend the Committee for taking up this very important topic, which is of great interest to our membership.

The P4P programs have appreciably advanced hospitals' focus on patient safety initiatives and outcomes—every hospital now has a dedicated effort to prevent infections, reduce readmissions, and improve patient satisfaction scores. While there is still much work to do, we are proud of our members' quality improvements results. GNYHA directly supports our members' efforts through innovative, hands-on quality improvement collaboratives such as our surgical site infection tracer program, which assesses hospital compliance with surgical safety checklists and protocols in the operating room and pre- and post-operative areas. We also have a joint initiative with our long-term care affiliate, the Continuing Care Leadership Coalition (CCLC), to improve hospital to nursing home transitions and reduce avoidable hospitalizations. In this effort, the focus is on standardizing communication protocols during the discharge and transfer process to ensure an effective and safe discharge to the most appropriate care setting.¹

GNYHA also regularly analyzes and deconstructs the Centers for Medicare & Medicaid Services' (CMS) methods for the P4P programs, and we offer extensive technical comments and input to the agency through the annual rulemaking cycle. We also provide analytical tools for our members to enhance their understanding of the P4P programs and methods, and how their performance on individual measures translates into payment adjustments. For example, we recently replicated and evaluated CMS's Overall Hospital Quality Star Ratings. It is with this background and experience that we comment today.

Background

There are currently five P4P programs in the Medicare inpatient prospective payment system (IPPS). The term P4P means that certain IPPS payments are adjusted based on whether, in any fiscal year, a hospital meets the criteria for avoiding a payment cut or earning a high performance payment. The first of the five programs, the inpatient quality reporting program, was implemented under the Medicare Modernization

¹ Funded with support from the United Hospital Fund.



GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

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Act of 2003, while the other core P4P programs were enacted in the Affordable Care Act (ACA). Figure 1 provides a brief description of each program and the types of measures used.

Figure 1. Current Inpatient Hospital P4P Programs

Program	Program Description	Measures
Inpatient Quality Reporting (IQR) Program (FY 2005)	IQR requires hospitals to successfully report on prescribed measures or incur a 25% reduction to the applicable fiscal year market basket increase. Savings accrue to the Medicare program.	Hospitals report on roughly 60 different measures, including chart-abstracted measures, patient satisfaction survey data, hospital infections, and structural registry use.
Meaningful Use (MU) Incentive Program (FY 2010)	Hospitals must achieve milestones representing the meaningful use of electronic health records or face a 75% reduction in the applicable fiscal year market basket index increase.	Hospitals must demonstrate proficiency in EHR use across nine different objectives, including health information exchange, patient electronic access, public health reporting, and computerized order entry.
Value-Based Purchasing (VBP) (FY 2013)	VBP cuts each hospital's operating base payments by 2% and the "pool" is distributed to hospitals based on relative performance. Hospitals are scored on applicable measures, earning achievement and improvement points, and individual measure results are "rolled-up" into a VBP score. The program is budget neutral to the Medicare program.	Hospitals will be evaluated on 15 quality measures across four domains in FY 2017: • Patient and caregiver-centered experience of care (25%) • Safety (20%) • Clinical care (30%) • Outcomes (25%) • Process (5%) • Efficiency and cost reduction (25%)
Hospital Readmissions Reduction Program (HRRP) (FY 2013)	The readmissions program cuts hospital operating base payments by up to 3% for hospitals with risk-adjusted readmission rates above the national average. Savings accrue to the Medicare program.	Hospitals are evaluated based on their 30-day all-cause readmissions rates for the following conditions: • Acute myocardial infarction • Heart failure • Pneumonia • Chronic obstructive pulmonary disease • Total hip and knee arthroplasty • Coronary artery bypass graft surgery
Hospital-Acquired Condition (HAC) Reduction Program (FY 2015)	The HAC reduction program imposes a 1% cut on a hospital's total IPPS revenue (including indirect medical education (IME), disproportionate share hospital (DSH), uncompensated care, Sole Community/Medicare Dependent Hospital, capital, and low volume payments) if the hospital's composite complication rate is in the worst quartile. Savings accrue to the Medicare program.	Hospitals are evaluated on performance across two domains: • Patient safety composite (25%) • Healthcare associated infections (75%) • Central line-associated bloodstream infection (CLABSI) • Catheter-associated urinary tract infection (CAUTI) • Surgical site infection (SSI)

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Estimated Fiscal Impact

Figure 2 presents the estimated impact of the five P4P programs on Federal fiscal year (FY) 2017 IPPS fee-for-service (FFS) payments for 3,218 affected IPPS hospitals.² The aggregate net loss to hospitals from the P4P programs—and savings to the Medicare program—is \$930 million, of which the largest source is the readmissions/HRRP program (57%) and the second-largest source is the complications/HAC program (40%). The quality reporting and MU programs provide negligible savings to the Medicare program, but notable losses to affected hospitals.

Figure 2. Estimated Impact of P4P Programs on FY 2017 Payments for P4P-Eligible Hospitals

	# Hospitals w/ Gains or Losses	\$ in Millions	Composition of Net Impact	% of Operating Base Payments
Payments before P4P adjustments:				
Total payments	3,218	\$115,504		
Operating base payments	3,218	\$85,879		
Impact of P4P adjustments:				
Quality reporting	117	(\$17)	2%	-0.02%
Meaningful use	169	(\$16)	2%	-0.02%
Readmissions	2,598	(\$529)	57%	-0.62%
Complications	743	(\$371)	40%	-0.43%
VBIP gains	1,801	\$172	-18%	0.20%
VBIP losses	1,233	(\$172)	19%	-0.20%
Interaction	2,757	\$3	0%	0.00%
Total	3,218	(\$930)	100%	-1.08%

Figure 2 also presents the impact of each P4P program as a percent of operating base payments. This denominator is used instead of total IPPS payments because it is the only component affected by all five P4P programs.³ The aggregate net hospital loss of \$930 million is roughly 1.1% of operating base payments, and the hospital level penalties generally top out at roughly 6%.

As shown in Figure 3, however, this impact varies by hospital cohort. (Hospitals eligible for at least one P4P program were assigned to mutually exclusive cohorts.⁴) Figure 3 orders the cohorts left to right, from the largest to the smallest P4P percentage loss. The cohort with the largest loss is major teaching hospitals (1.7%), followed by the four DSH cohorts *in descending order of their DSH burden*: high DSH (1.2%), medium-high DSH (1.1%), medium-low DSH (1.0%), and low DSH (0.6%). Sole community and Medicare-dependent hospitals have an even smaller loss than low DSH hospitals (0.5%), and low volume hospitals have the smallest loss (0.4%).

² GNYHA analysis is based on payment parameters and hospital variables in the CMS FY 2017 IPPS Impact File.

³ One of the complexities inherent in five separate P4P programs is that the penalties are applied to different elements of the IPPS rates. There are also interactions between the P4P adjustments and other policy adjustments such as indirect medical education (IME), disproportionate share hospital (DSH), and low-volume payments.

⁴ Hospitals were assigned to cohorts in the following order: 1) SCH/MDH: hospitals receiving supplemental Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) payments; 2) Low Volume: hospitals receiving low volume payments that were not in the SCH/MDH cohort; 3) Major Teaching: teaching hospitals with a resident-to-bed ratio at or above the 75th percentile and not otherwise already assigned; and 4) all remaining hospitals, grouped to either the High, Medium-High, Medium-Low, or Low DSH cohorts based on the quartile ranking of their disproportionate patient percentages.

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Figure 3. Estimated Impact of P4P Programs on Mutually Exclusive Hospital Cohorts

Percent of Operating Base Payments	All Hospitals	Major Teach	High DSH	Med- High DSH	Med- Low DSH	Low DSH	SCH/ MDH	Low Vol
<i>Number of Hospitals</i>	3,218	259	542	541	541	542	420	373
Quality reporting	-0.02%	-0.03%	-0.02%	-0.01%	-0.02%	-0.01%	0.00%	-0.11%
Meaningful use	-0.02%	-0.03%	-0.03%	-0.01%	-0.01%	-0.01%	0.00%	-0.05%
Readmissions	-0.62%	-0.62%	-0.60%	-0.62%	-0.68%	-0.54%	-0.54%	-0.63%
Complications	-0.43%	-0.84%	-0.42%	-0.38%	-0.27%	-0.30%	-0.32%	-0.22%
VBP net gains/losses	0.00%	-0.17%	-0.11%	-0.06%	0.01%	0.22%	0.38%	0.57%
Interaction	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	-1.08%	-1.67%	-1.18%	-1.09%	-0.97%	-0.64%	-0.48%	-0.43%

The VBP program mirrors Figure 3's cohort order. Major teaching, high DSH, and medium-high DSH hospitals all have net losses, while the other cohorts have net gains to help offset losses from the other P4P programs. Major teaching hospitals and most DSH hospitals also have above-average losses from the readmissions program, but major teaching hospitals have the largest loss because of disproportionate losses in the HAC reduction program.

Proposal for an Improved VBP Program

The P4P programs are only six years old, but much has been learned during this period. The key finding is that some of the technical methods used in the programs—including some methods embedded in the ACA—create systematic risk for certain types of hospitals. This means that certain types of hospitals have unfavorable results due to factors beyond their control. It is important for Congress to develop a second generation hospital inpatient P4P program that will better control for systematic risk and improve the program's validity and fairness.

Before suggesting ways to design a consolidated P4P program, we would like to review our concerns about the current programs.

Concerns about the Current P4P Programs

Complicated program structure. Inherent in the fact that there are five P4P programs is a complicated program structure that is not well aligned across programs. Each program has its own relatively sophisticated scoring methodology that embeds different policy preferences. For example, the VBP and HAC programs rank-order hospitals based on performance and confer points based on the decile of performance. This is a concern because it ignores the statistical significance of performance variation, so penalties are imposed for insignificant performance differences. In addition, only the VBP program confers points both on achievement and improvement, meaning that hospitals subject to penalties in the other programs have to improve more than other hospitals in order to reduce their financial impact, which is very difficult. Further, the HRRP and HAC program benchmarks are not set in advance, so hospitals do not know if improvements will translate into lower penalties. Taken together, this leaves the average hospital with little ability to understand how performance on a single quality measure impacts its performance-based payments and how to optimize its quality improvement efforts accordingly.

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Measure duplication across programs. There is currently measure duplication both *within* programs, as evidenced by two different CLABSI measures within the HAC reduction program, and *across* programs, as evidenced by the CLABSI and CAUTI measures being included in both the HAC and VBP programs. In fact, 100% of the measures included in the HAC reduction program are also included in VBP. The presence of duplicate measures is not only burdensome, but can lead to confusion because of the different time periods, measure specifications, and scoring methods used across programs. Further, hospitals can be penalized twice for their performance on overlapping measures. The ACA acknowledged this problem, by expressly preventing measure duplication in the VBP and readmissions programs, but a similar provision was not included for the VBP and HAC programs. Although CMS could administratively remove the HAC measures from the VBP program, it has declined to do so.

Measure fatigue and complex reporting requirements. Hospitals suffer from measure fatigue and complex quality reporting requirements. These requirements are modified each year, with some measures removed and others added, but are never reduced and the administrative cost has grown apace. The burden of this activity diverts focus and resources from hospital quality improvement efforts. Unfortunately, there is also little measure alignment across payers, so hospitals must report a different measure set to private payers and state Medicaid programs.

Excessive penalties in certain programs. At the hospital level, the net fiscal impact across the five P4P programs ranges from negative 15.3% to positive 3.8% of operating base payments. Combined, these programs put hospitals at too great a financial risk. Also, because of design concerns discussed below, the readmission and HAC penalties are outsized relative to other measure domains such as mortality or efficiency. Over half of the penalties' aggregate net impact (57%) is from the readmissions program and 40% is from the HAC program. Combined, these programs cut hospitals by \$900 million.

VBP program over weights patient satisfaction. The VBP program over weights the Patient-Centered and Caregiver Experience of Care domain (25% of the total score) based on hospitals' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. This disadvantages safety net hospitals because they tend to score worse than non-safety net hospitals on patient satisfaction surveys. Safety net hospitals have lower overall margins, less staffing, and older capital plants with fewer amenities. This leads to inefficient facilities, fewer single-patient rooms, more noise, and other conditions that make them less appealing. But the scores are not risk-adjusted for these factors, which disproportionately affect hospitals that principally rely on government payer revenue.

CMS does, however, risk-adjust for certain patient characteristics, systematically downgrading the scores of patients who are relatively less educated, in worse health, and for whom English is not their primary language because they tend to give higher scores than other patients. It is unfair to redistribute such a significant amount of funding to hospitals in more affluent communities without also risk-adjusting for facility factors that are generally beyond management's control.

Problems with the readmissions program. We have three main concerns with HRRP: 1) the 30-day readmission measure is not a measure of hospital quality but rather the availability of community-based care; 2) the lack of risk adjustment for socioeconomic, demographic, and environmental risk-factors of

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patients; and 3) significant technical flaws in the construct of the readmissions penalty formula. Each of these problems is described below.

- Measures don't reflect hospital quality but rather availability of community-based care.** CMS has adopted a 30-day all-cause readmission measure to evaluate hospital readmissions for six clinical conditions. The 30-day timeframe extends far beyond what the hospital itself can control. Rather than being a reflection of hospital quality, it measures patient and caregiver compliance with post-discharge instructions, availability of transportation, and access to appropriate community-based follow-up care. As a measure of *hospital* quality, a seven-day readmission measure would be far more appropriate because this would reflect problems with hospital care such as a surgical infection, HAC, poor discharge instructions, inappropriate early release and/or discharge destination.
- Lack of risk adjustment for Socioeconomic Status (SES).** The challenges for hospitals treating patients with low SES status are well documented, as is the disproportionate impact of the readmissions penalties on safety net hospitals. Yet, CMS fails to risk-adjust the readmission rates for the sociodemographic patient factors that are beyond the providers' control, such as patient difficulty understanding discharge instructions because of poor health literacy or limited English proficiency, not having a regular source of primary or specialty care, or no family member to help with convalescence post-discharge.

GNYHA commends the Committee for addressing this issue in House-passed H.R. 5273, *Helping Hospitals Improve their Care Act*. Among other improvements to the readmissions program, the legislation would require the Secretary of Health and Human Services (HHS) to evaluate hospitals against a peer group of similar hospitals, based on their proportion of dual-eligible patients. The Secretary could refine this approach in future years based on study results on SES factors required by the IMPACT Act. We strongly urge the Senate to adopt similar legislation.

- Flaws in the readmissions penalty calculation.** GNYHA also has serious concerns about HRRP penalty calculation flaws that result in penalties that are far higher than the Medicare payments for the readmissions, and penalties that remain constant while industry readmission rates decrease. Over time, these characteristics will become significant deterrents for hospitals to take action and focus on improving readmission rates because they push hospitals to the 3% penalty cap.

The HRRP statute includes a multiplier on hospital penalties for each condition such that the penalty is a multiple of the actual cost to the Medicare program for the readmissions. As shown in Figure 4, the multiplier varies by condition and is the reciprocal of the national average readmission rate, so the lower the average readmission rate the higher the multiplier. And as hospitals decrease readmission rates, the multipliers increase. The penalties for heart attack, for example, are six times the cost of the readmissions, but for hip and knee replacements, they are *over 20 times the cost of the readmissions*. This is an issue of great urgency because with each passing year, as more conditions are added to the HRRP, a legislative "fix" becomes more expensive. Further, if CMS were to adopt a 30-day hospital-wide readmission measure, as proposed in President Obama's budget, GNYHA estimates that the aggregate penalty would quadruple to over \$2 billion because of the multiplier, and would be untenably higher without the 3% statutory penalty cap.

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Figure 4. Effect of the HRRP Multiplier

HRRP Condition	National Readmission Rate %	Penalty Multiplier
Acute myocardial infarction (AMI)	16.8%	5.0
Heart failure (HF)	21.9%	4.6
Pneumonia (PN)	17.1%	5.8
Chronic obstructive pulmonary disease (COPD)	20.0%	5.0
Total hip arthroplasty (THA) and total knee arthroplasty (TKA)	4.6%	21.7
Coronary artery bypass graft (CABG)	14.4%	6.9

The current statute also fails to give the industry "credit" for the Medicare savings associated with reduced readmissions since HRRP's inception. Consequently, as the national readmission rate goes down, an average hospital's readmission penalty will remain roughly constant, essentially allowing the Medicare program to benefit twice (from reduced payments to hospitals for the readmissions that were averted, and the readmissions penalty). Congress must pass legislation to fix these problems with the readmissions penalty even if it chooses to not pursue a consolidated VBP program.

HAC program unfairly penalizes teaching hospitals. The penalty structure is problematic because one-quarter of the nation's hospitals are always subject to the penalty, regardless of whether hospitals are performing well on the measures or there are national improvements in complication rates. In addition, because hospitals are simply ranked, the statistical significance of performance differences is not considered. Further, because the reliability adjustment in the methodology essentially assigns rural and small community hospitals the national average performance, they rarely receive a penalty because they have little opportunity to be in the bottom quartile. This results in large, urban teaching hospitals being disproportionately penalized.

Unlike the other ACA P4P programs, the 1% penalty is applied to *all* inpatient payments. This results in an outsized penalty for affected hospitals. Therefore, as a percentage of base operating payments as opposed to total payments, the penalty ranges from 1.1% to over 11%, with 40 hospitals experiencing a cut of 2% or more.

Little relationship between P4P penalties and Star ratings. We regressed the dollar value of the penalties under the P4P programs with the recently released CMS Overall Hospital Quality Star Ratings, and found an R^2 of only 28%, meaning that the Star scores—the public indicator of hospital quality—do not effectively predict hospital P4P losses. While we have serious concerns about some design features of the Star ratings, namely that they give too much weight to the inadequately risk-adjusted patient satisfaction and readmissions measures, we are also concerned that this sends mixed-messages about Medicare's view of an individual hospital's quality performance.

Concepts for an Updated Performance-Based Payment Program for Hospital Inpatient Services
HHS issued its *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* in November 2007. While that nine-year-old plan continues as the structure of the VBP program today, two recent events have advanced the thinking about performance-based payment: consolidation of the quality reporting, MU, and value modifier programs in the physician Merit-Based Incentive Payment System (MIPS), and the use of latent variable modeling in the Star rating system.

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We like the streamlined effect of designating quality reporting and MU as domains of a single performance-based payment system, and we appreciate the sophistication and elegance of latent variable modeling to derive domain scores, which the Star rating system calls standardized group scores. We therefore recommend consideration of an updated hospital VBP program that adds together payment adjustments for quality reporting, MU, and performance in order to derive a single VBP adjustment to operating base payments. If the performance component of the new VBP adjustment replaced the current VBP, readmissions reduction, and HAC reduction programs, that would obviate the need to make technical improvements to those programs, provide an opportunity to use latent variable modeling to derive domain scores, and rebalance the impact of each domain on the hospitals' aggregate P4P adjustment, which today is overwhelmed by the readmissions and HAC penalties.

In fact, we strongly urge Congress and the Administration to eliminate the 30-day readmission domain from both VBP and the Star rating system because, as noted earlier, 30-day readmissions are not an appropriate measure of inpatient performance. Instead, we recommend developing seven-day readmission measures that could be classified as complications. Alternatively, the 30-day readmission domain could receive the lowest weighting in a total performance score (VBP) or hospital summary score (Star ratings).

We further recommend aligning the domains in the VBP and Star rating programs and rethinking the domain weights in both programs. Figure 5 shows the current domain weights in VBP and the Star rating system. If a new VBP program replaced the current VBP, readmissions reduction, and HAC reduction programs, as offered for consideration, we assume CMS would add readmissions as a domain in VBP and weight it equally with the other domains.

Figure 5. Domains and Domain Weights in the VBP and Star Rating Programs

Generic Domain	VBP			Star Rating System	
	Domain	FY 2019	If No HRRP	Group	Weight
Mortality	Clinical Care	25%	20%	Mortality	22%
Complications	Safety	25%	20%	Safety	22%
Evidence-based medicine				Effectiveness and timeliness of care	8%
Patient experience	Person and Community Engagement	25%	20%	Patient experience	22%
Efficiency	Efficiency and Cost Reduction	25%	20%	Imaging efficiency	4%
Readmissions	Readmissions		20%	Readmissions	22%
Total		100%	100%		100%

There are two principal differences between the programs. First, CMS is phasing evidence-based measures out of VBP, but includes them in the Star rating system. Second, CMS defines the VBP efficiency domain as measures of Medicare Spending per Beneficiary, but declined to use those measures in the Star rating system, saying it was unclear whether high or low standardized spending was more favorable. These conflicts should be resolved, especially regarding the efficiency domain because standardized spending per beneficiary is the cornerstone of CMS's Alternative Payment Models (APM) and its new mandatory bundled payment programs.

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In addition, and in our view more importantly, we strongly urge policymakers to reweight the domains to align better with patient priorities and to lessen the effect of systematic risk (bias) in some of the measures. When being admitted to the hospital, a patient's top priority is no doubt survival and avoiding a medical complication, so we would give the highest weight to mortality, then complications, then evidence-based medicine, then patient experience, which includes communication and discharge planning. We assume the efficiency domain will eventually migrate to APMs and bundled payments, but would give it a low weight in the meantime. Again, we would eliminate the 30-day readmissions domain and replace it with seven-day readmissions measures in the complications domain.

Finally, if an updated VBP program replaces the five disparate programs, current Medicare program savings from the quality reporting, MU, readmission reduction, and HAC reduction programs can be: 1) eliminated (ideally), 2) converted into a permanent adjustment to the operating Federal rate so the VBP program can continue to be budget neutral, or 3) built into the VBP program as a fixed percentage of FFS base operating payments. If the third option is used, the new VBP program would both generate the requisite program savings and finance a high performance fund.

As Congress considers these issues, we also encourage it to adopt similar performance-based incentives in the other provider sectors using the lessons learned from the hospital P4P programs so that the financial incentives to improve quality and efficiency are aligned across sectors. This is especially important as providers work collaboratively to implement APMs for bundled payments or for the total cost of care in the case of accountable care organizations. Successful adoption of these models may be the only viable option for hospitals with a high Medicare and Medicaid payer mix to financially sustain their operations.

Conclusion

Thank you for the opportunity to testify. GNYHA encourages the Committee to consider these issues as it pursues its agenda to improve Medicare performance-based payments this fall. We believe that if adopted, the recommendations would improve the quality, efficiency, and fairness of the Medicare program. Even if the Committee does not put forth a comprehensive update of the current P4P programs, we hope it will at least address our technical and policy concerns about the readmissions program.

Chairman TIBERI. Thank you.
Mr. Guenthner, you are recognized for 5 minutes.

**STATEMENT OF C. STEVEN GUENTHNER,
PRESIDENT, ALMOST FAMILY, LOUISVILLE, KENTUCKY**

Mr. GUENTHNER. Thank you, and good afternoon, Chairman Tiberi, Ranking Member McDermott and Members of the Committee. On behalf of Almost Family, I am absolutely thrilled to be here today as a participant in the evolution of quality in Medicare.

Almost Family's experiences navigating changes in Medicare span four decades. I have been a member of its executive team for 25 years and its President since 2012. Our cornerstone belief is that the needs of patients must always come first. It is how we operate our business at Almost Family, and it is how we approach the evolution of quality in Medicare.

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. The ideal VBP would redistribute payments to providers not only within a payment silo but also across payment silos, with the goal of getting patients to the best-value care setting for their needs. We need to change the policy question from how should we pay providers to how we should care for patients. This is especially important in the context of quality discussions.

VBP must address first the measures to be used and, second, how much financial risk providers should bear. In a post-acute VBP, the following simple measures are best: One, hospitalization; two, emergent care without hospitalization; three, restoring the patient's previous level of functionality—now, this is the measure that is the most important to patients; and, four, the cost incurred to achieve those outcomes.

On financial risk, too little could be ignored by providers, and too much could drive unanticipated outcomes. We believe the sweet spot to balance these concerns is somewhere in the 2 to 5 percent range of provider payments. We would not support more than 5 percent at risk.

Now, I know I am here as a representative of post-acute providers, but I have to object to the unnatural grouping of dissimilar providers currently included in most post-acute discussions. This group runs the gamut from LTACs, which are actually hospitals, all the way to home health care. Home health could be considered the ultimate post-acute care, getting patients back home, but home health also plays a vital role in avoiding acute care, especially for the chronically ill patients.

Some thoughts on chronic care: As your own Committee pointed out in your 2015 stakeholder request, chronic illnesses such as heart disease, diabetes, and cancer now account for over 90 percent of spending. We simply cannot solve the Nation's post-acute care delivery and spending problems unless we address chronic illnesses.

We have proposed a number of reforms designed to help keep chronically ill out of institutions and in their own homes, managing their conditions under the supervision of their primary care physicians. To address chronic care needs, we propose closing the biggest

single gap in Medicare today, and that is the absence of effective care management and care coordination processes.

Managing chronically ill patients at home helps avoid both acute and post-acute care costs. We think one of the best ways to do that is to bifurcate or split the home care benefit into two pieces, one post-acute and one chronic care, to separately address the needs of those patients at their different stages in their healthcare journeys.

A note on regulatory relief: Sometimes well-intended policies can go awry and require regulatory relief, such as the requirement for a physician face-to-face encounter with a patient in certifying the need for home health services. The statute was fine; unfortunately, it was not well-implemented in regulation.

CMS has fixed some of the problems, but we are left with an over-reported error rate in home health payments. This now has CMS implementing a pre-claim review process that we expect to add significant burden and create unanticipated consequences, not to actually reduce improper payments or improve quality but, rather, to fix documentation issues that were brought about by subjective regulations. CMS expects to spend about \$300 million to address this.

We ask you, please consider legislative fixes to the home health face-to-face and pre-claim review process, and also please address the appeal backlog that—in a similar fashion, this was done with the hospital appeal backlog some years ago.

I have one final topic, which is on payment safeguards. Since 2011, Almost Family has proposed to drive cost savings through a home health payment safeguard patterned after the proven outlier limit, which has saved the Medicare program \$1 billion a year. We estimate this equally practical safeguard will save another \$600 million a year. And, sadly, while we have been advocating this, \$5 billion has gone out of the Federal Treasury, in our view, unnecessarily. We ask, please do not miss this opportunity to capture these savings in your legislation.

Thank you so much for letting me be here today and allowing Almost Family to be a part of this process, and we look forward to your questions.

[The prepared statement of Mr. Guenther follows:]



September 7, 2016

The Honorable Pat Tiberi

Chairman

Committee on Ways and Means

Subcommittee on Health

1102 Longworth House Office Building

United States House of Representatives

Washington, D.C. 20515

The Honorable Jim McDermott

Ranking Member

Committee on Ways and Means

Subcommittee on Health

1106 Longworth House Office Building

United States House of Representatives

Washington, D.C. 20515

Chairman Tiberi, Ranking Member McDermott and Members of the Subcommittee:

Almost Family, Inc., one of the nation's largest home health providers and one of the largest ACO managers, is honored to provide this testimony in response to the invitation of the Subcommittee to participate in a hearing on "The Evolution of Quality in Medicare Part A", in particular as it relates to post-acute care (PAC). The foundation of our Company is our mission of Senior Advocacy, through which we look beyond the obvious helping seniors manage the aging process, including chronic illness, and to remain in their homes for as long as possible. Our experiences in the provision of skilled in-home nursing care, personal care services, ACO management and health innovation strategies give us a unique perspective on Medicare (the Program), in particular post-acute care, and chronic conditions. Our experiences navigating changes in Medicare for over 35 years also position us well to advise on the evolution of the Program and proposed reforms to be discussed today.

Throughout the course of our testimony we focus on the following five points:

1. *Medicare reforms should be patient-centric rather than provider-centric.*
2. *Value-based purchasing (VBP) is the logical next step in managing care, but must be appropriately designed to include the right quality measures and properly-aligned incentives. Quality measures used in any VBP program should prioritize patient-based metrics.*
3. *Home health patients would benefit greatly from regulatory relief in the form of legislative fixes to Face-2-Face, Pre-Claim Review and the ever-increasing backlog of ALJ appeals. Reducing administrative burdens helps providers focus on the needs of patients.*
4. *Program integrity initiatives are an essential part of post-acute reform including our proposed Payment Safeguard which would save Medicare up to \$600 million annually.*
5. *We also propose several Medicare reforms to better meet the needs of patients, improve quality and lower cost.*

We Invite You to Read Our Previous Submissions

Much of what we share with you comes from a series of stakeholder comment letters we have provided for the past several years to Ways & Means, Senate Finance and CMS. We refer to these works below and provide links for easy retrieval:

- [PAC Reform Stakeholder Letter – August 2013](#)
- [Chronic Care Stakeholder Letter – June 2015](#)
- [Medicare Shared Savings Program – February 2015](#)
- [Home Health VBP and Quality Reporting – September 2015](#)
- [Comprehensive Care for Joint Replacement Payment Model – September 2015](#)
- [Chronic Care Working Group Policy Options – January 2016](#)

In this testimony we address how this work informs our views on the subject of the hearing.

The Evolution of “Quality” Should Drive Patient-Centric as Opposed to Provider-Centric Reforms

We believe patient-centric concepts must replace provider-centric concepts across the entire Medicare Program. The best definition of quality is one centered on patients, nearly all of whom really want to live in their own homes for as long as possible. When patients suffer an acute event or exacerbation of a chronic illness, they want prompt, effective medical care, in whatever venue is appropriate, and they want to return home to recover, to the extent possible, to their previous level of functionality – and to return to their normal lives. We strongly believe that the “Evolution of Quality in Medicare Part A” should deliver this result to America’s seniors, and that one of the best ways to achieve this is through a well-designed value-based purchasing program.

Value-Based Purchasing – is the Next Step in Managing Quality and Cost

We have consistently supported value-based purchasing for several years. Quoting from our 2013 PAC stakeholder comment to House and Senate committees of jurisdiction:

“We must embrace, sooner than later, the principles of quality, assessment tools and value-based purchasing. We have data to properly measure results and we need to pay for results, both quantitative and qualitative. Rather than waiting for a perfect system, we should get started with what we have and make improvements as we go. We believe providers will immediately respond to these new incentives which will significantly benefit the Program.”

We loudly applaud the efforts of the Committee, CMS and others to take full advantage of VBP to continue the movement from volume to value. We have long advocated developing payment policy around what the Program wants providers to do. This marks an important inflection point in the dialogue between the Program and providers. The Program can clearly say “This is what we want you to do” and providers are then charged to do that thing -- to be measured and held accountable through financial incentives, STAR ratings and other means, to perform to objective standards.

We must move from “reimbursing providers for costs” and towards “rewarding providers for creating value”. If that creates inconsistent margins across payment silos, so be it. Lower value services *should* have lower margins to discourage their use. Higher value services *should* have higher margins to encourage their use. ***The quest for consistent margins will defeat aligning payments with value.***

Home health is currently subject to a CMS value-based purchasing demo, which impacts about half of our Company’s business. I can assure you no reputable provider wants to be viewed as low quality. Across all demo states providers are working to excel at the measures set forth by CMS.

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September 7, 2016**

In our view, there are two key aspects of good VBP design:

- **Quality Measures Should be Patient-Based:**
 - There should be fewer and smaller sets of measures more narrowly focused on the Program's desired goals. Specifically, we propose:
 - a. Hospitalization;
 - b. Emergency Room use without hospitalization;
 - c. Restoring previous levels of functionality (primarily activities of daily living)
 - d. All balanced against the costs incurred to achieve the goals.
 - We caution against using too many individual measures – this dilutes focus. With too many measures no one measure carries very much weight.
- **Financial Risk and Incentives for Providers Should be Properly Sized:**
 - We are big fans of providers bearing responsibility for delivery, the results and the cost of care. But, what is the right amount of financial risk?
 - Too little might be ignored by providers, too much could cause unanticipated behaviors and undesirable disruptions to good patient care.
 - In the early phase of this program we favor exposure in the 2%-5% range as being enough to get providers' attention without overdoing it.
 - We would not be in favor of more than 5% at risk.

We are a long-time supporter of the IMPACT Act as we wrote in two letters of support to Ways & Means and Senate Finance in 2014 and 2015. In particular, we support the goals of developing a consistent set of measures that enable meaningful comparison across provider "silos". However, we continue to have *serious* concerns about the unnatural grouping of dissimilar providers being categorized as "post-acute". We discuss this problem more below.

We strongly agree with the view that the set of measures used by CMS in its VBP programs should be reconciled with those of the IMPACT Act as soon as possible.

Legislation Should Fix Home Health Face-to-Face, Pre-Claim Review and the ALJ Backlog

The home health face-to-face physician requirement was not well implemented. Although now-reversed, the ill-advised subjective narrative requirement *has created the appearance of sky-rocketing error rates* in the Medicare Comprehensive Error Rate Testing process. CMS's own regulatory roll-back has addressed some of this, however, we are left with the *legacy of an over-reported error rate* in home health. While well-intended, CMS now seeks to address those flaws with an under-developed and potentially also flawed pre-claim review process. We expect this to cost the taxpayers over \$300 million and create significant administrative burden, not to actually reduce improper payments, but rather to fix documentation issues created by the face-to-face regulations.¹

Meanwhile the Administrative Law Judge dockets are still jammed with tens of thousands of appealed face-to-face denial cases that will almost certainly be overturned in favor of beneficiaries.

We strongly support any efforts of this Committee to resolve this unfortunate situation through legislatively driven corrections to the over-reported error rate and through a global appeal settlement as was done with the hospital appeal backlog some years ago.

¹ Centers for Medicare & Medicaid Services (CMS), "Supporting Statement Part A: Pre-Claim Review Demonstration for Home Health Services," CMS-10599/0936, July 1, 2016, page 6. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10599.html>

Our Payment Safeguard Provides Meaningful Savings

We have a specific proposal to drive measurable savings through implementation of a home health payment safeguard. The home health outlier limit, proposed by the home health industry and implemented by CMS in 2010, clearly worked. It has saved Medicare approximately \$1 billion per year. We have been persistent advocates of a similar reform in previous stakeholder comment letters to Congress and CMS. We estimate this reform, patterned after the outlier limit, will save another \$600M per year. Since we have been advocating this second, equally practical payment safeguard, over \$4.5B has gone out of the Federal treasury unnecessarily.

We urge the committee to consider our proposal on its merits for possible inclusion in any legislation.

We Must Move Toward Patient-Centric Payment Policies

We believe reform among post-acute sectors must shift from provider-centric to patient-centric policies. From its origin, the Medicare Program has been hospital-centric. Medicare's cornerstone, Part A, was hospital insurance designed first to cover inpatient care. This was a reflection of the state of the US healthcare system in 1965, the year of Medicare's foundation. In that year, fully one-half of our older population had no coverage at all. Everyone knew, if you got sick the first thing you did was go to the hospital. The legacy of this concept, combined with the economic gravity of the dollars involved in this highest-cost care setting has transcended the decades.

Hospitals, including LTACHs and IRFs, are valuable and important parts of our health care delivery system. Like all sectors, they must be maintained in a viable state through good policy and appropriate reimbursement, which means serving patients in the most appropriate and lowest-cost setting.

In fact hospitals, home health and other provider types must partner together to produce the high-quality, low-cost care-coordination and care-transitions patients truly deserve.

While our commitment to caring for our seniors is unwavering, we know the current system is financially unsustainable. Additionally, we have many tools and care venues available to us that simply didn't exist in 1965. Scientific and technological advances, together with new ideas, like using risk-based predictive models, home health care interventions, and the sharing of information to support better clinical decisions are now available to allow us to shift from a hospital-centric to a patient-centric perspective. This is the central theme we support through the balance of this document.

One Payment System for all "PAC" Providers -- As Defined -- Is Not a Good Idea

The unnatural grouping of dissimilar provider types included in most PAC discussions has evolved from historical rate-setting silos and practices designed to "reimburse providers for the costs they incur" rather than "reward providers for the value they add". Attempts to bundle payments within this unnatural group of dissimilar providers may be unlikely to achieve the desired result and other options should be contemplated.

Under a different definition more appropriately aligning actual PAC providers -- SNFs, Home Health and Hospice -- a single PAC payment system may be appropriate.

We Should Challenge the Definition of "Post-Acute" Care

We respectfully suggest that the following, while commonly used in numerous PAC reports and literature, should be challenged:

- Challenge Point: Health care services delivered up to and through an acute care hospital stay are essentially deemed reasonable and necessary. By the time a patient is admitted to a hospital they really needed it and it couldn't be avoided. Now we need only really concern ourselves with what to do post-discharge from the hospital.
- Challenge Point: The health care "continuum" is somehow a sequential journey in which patients first must leave their homes and be admitted to a high-cost in-patient facility before their care needs can actually be legitimized. This is even rooted in the Medicare statute -- a "spell of illness" begins on the day of admission to a hospital (SSA Sec 1861(a)).
- Challenge Point: Home health care is a subset of post-acute care. In reality post-acute care is a subset of home health. We propose that, while home health care is very effective in meeting post-acute care needs, it can be even more valuable in helping the Program avoid not only unnecessary **Re-Admissions** but in helping to avoid unnecessary **Admissions** to start with.

The discussion must move directionally from "How do we manage the costs of care post-hospital discharge?" toward "How do we keep patients from winding up in the hospital in the first place?"

This calls for redefinition of the phrase "post-acute" and reconsideration of the goals of payment policy.

LTACHs are Hospitals, Not "Post-Acute". The very name of the segment, "Long Term *Acute* Care Hospitals", articulates acute versus post-acute. The only discernible difference from short term acute care hospitals is in the required average length of stay.

Half of Home Health Care is Pre-Acute. CMS data indicates that one-half or more of the home health spend is on patients admitted directly from the community rather than on discharge from inpatient facilities. We recognize that some have questioned the appropriateness of community based home health admissions. However, when appropriately used, we know home health care adds significant value to the Program to avoid unnecessary inpatient stays. In contrast, having its use validated as "truly medically necessary" by the fact that it is preceded by a high-cost inpatient stay would mandate incurring the high-cost charge to validate the use of the low-cost alternative.

IRFs are Mostly in Acute Care Hospitals. According to MedPAC and CMS the vast majority of IRFs (and LTACHs) are actually located within the walls of acute care hospitals. So in these cases, so-called "post-acute" care just moves the patient from one part of the hospital designated as acute care, to another part of the hospital designated as "post-acute". The distinction is meaningless to the patient who has not even left the building, to them, they are still in the hospital.

Hospice is Post-Acute. We object to the routine absence of hospice from the discussion of PAC. Hospice should be a critical part of this discussion. Many a patient has been "sent home with hospice" after acute care solutions have been exhausted. Nothing could be more "post-acute" from the patient's perspective and yet it is absent from nearly every PAC discussion. Notably, 96% of all hospice days of care are provided in patients' homes.

Patients Matter More than Providers – Which Should Guide Medicare Reform

We offer the following common-sense thesis regarding all patients:

For patients, health care begins, and ends, at home. We must recognize, and build our health care systems around the reality that patients start their health care journey at home. Whenever possible, we should seek to manage patients' care at home and whenever that's not possible, our goal must be to return patients to their homes at the earliest, safest, most economical point in their journey. Once returned to their homes, we should seek to keep them there and out of high-cost institutions.

In the context of "post-acute" care, where "post-acute" means discharge from an inpatient facility reimbursed as a short term acute care hospital, we suggest that the following framework prove very useful in contemplating the management of patient populations. The following graphic portrays steps towards a unified system of assessment and management of chronic illness.

A Suggested Framework to Move Toward Patient-Centric Reforms	
Category 1: Shorter term, procedurally "fixable" conditions, or those more discreetly identifiable to a particular sentinel incident such as a stroke, heart attack or fall.	Patients where the acute care preceding the "post-acute" care is either incidental to the disease state, or the patient was otherwise in reasonably good condition prior to the inpatient admission. These are predominantly surgical cases with post-surgical follow-up care. The easiest example to understand is the otherwise reasonably healthy senior who has a joint replacement. In these categories the acute care procedures largely "fix" the patient's issue and the patient recovers and returns to a normal life.
Category 2: Longer-term, clinically more complex, "non-fixable" conditions that must be managed more comprehensively	Patients with disease states that will NOT go away following the acute care stay. In many, if not most, of these cases the acute care stay is a part of the disease state progression that could actually have been avoided with the right kind of PRE-ACUTE care. The easiest examples to understand in this category are Congestive Heart Failure, COPD and Diabetes where the acute care stay is a manifestation of a failure to otherwise manage the patient in their own home. <i>The key to managing costs for this patient category is to "stay ahead" of the disease state and to avoid the acute care stay to start with.</i>

In our practice at Almost Family, we see a broad variety of patients but they can generally be categorized into the two groups outlined above. We believe our patient populations are fairly representative of the population as a whole. Thus, contemplation of what we see should prove useful. While this is arguably clinically simplistic, we believe considering the needs of the patients, more than how to "reimburse provider categories for their costs", will drive superior policy.

With this type of "patient-centric" perspective we can now begin to reshape thoughts about the management of these patient populations, whether in a hospital, some other institutional setting or their own homes.

Avoid the Acute Care Stay and Avoid Post-Acute Care Costs – Through Chronic Care Management

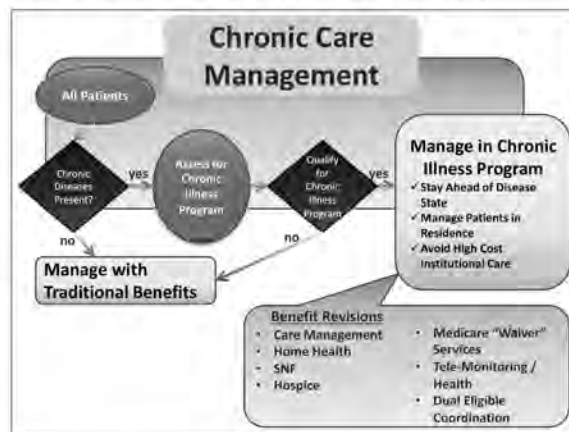
There are two fundamental gaps in Traditional Medicare that must be addressed:

- Medicare was designed primarily to be a short-term benefit, but the chronic conditions that drive much of Medicare's costs are in fact *long-term* conditions that must be managed.
- The absence of objective assessment and care management processes in Traditional Medicare to manage these chronic conditions leaves the Program with the obligation to pay claims, but minimal opportunity to manage costs other than by managing provider categories and cutting rates.

Treatment of chronic illnesses such as heart disease, diabetes, and cancer—just to name a few—now accounts for almost 93 percent of Medicare spending. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending in a recent year. Finally, Traditional Medicare spends an average of over \$32,000 per beneficiary with six or more chronic conditions compared to an average of less than \$10,000 for all other beneficiaries.

We simply cannot solve the post-acute care problem without addressing management of chronic conditions.

In our June 2015 Chronic Care white paper we proposed establishment of a new benefit within Traditional Medicare specifically for the management of chronically ill patients, depicted in the following graphic:



Our view is to manage the patient rather than the provider type with the following *package* of services:

1. **Primary care is central.** The Primary Care Physician (or PCP) rather than the payer must be the central control point for utilization management and must be adequately trained, informed, empowered, protected, compensated and incentivized to act as such. Policies should encourage the efficient use of physician extenders whether in the PCP's office, in the patient's home or in both, under the supervision and control of the PCP.
2. **Care management must be integrated.** Care management, using evidence-based clinical standards, must be integrated into Traditional Medicare as an essential part of utilization management. This is a feature largely lacking in the current system. In our 2015 Chronic Care white paper we made specific proposals for

implementation into the traditional program in a section labeled “Chronic Care Management – A Model for Consideration”. We encourage the Committee to consider this proposal as it pursues its work.

3. **Home first and always.** Recognize that the home is both the start and the end of the health care experience for patients. At every step, treating clinicians must ask and answer: *“How do I get this patient home as soon as safely possible?”*
4. **Low cost before high cost.** Low cost alternatives should be evaluated and eliminated, or tried and exhausted, **FIRST** before patients can be admitted to higher cost service settings. At every step, treating clinicians must ask and answer: *“How do I safely care for this patient at the lowest cost possible?”*
5. **Attestations and incentives should be used in concert.** Two primary tools are available to the Program: 1) mandating certain provider actions including clinician attestations as to medical necessity and appropriateness and 2) establishing financial incentives that encourage desired behaviors. These must be embraced in concert to guide patients to the most appropriate care settings. Examples include:
 - a. **Provider actions and attestations:**
 - i. Establishing requirements and payments for PCPs and others to provide care management services.
 - ii. Requiring all inpatient facilities to timely inform PCPs regarding admission and discharge processes enabling PCPs to participate in clinical decisions. *Amazingly, this does not happen with consistency in practice today presenting one of the more significant obstacles to care transitions. Our ACO physicians commonly state that a primary problem in managing patient admissions, post-acute care and readmissions is that they often do not even know it is occurring until after the fact.*
 - iii. Requiring clinical certification as a part of all admission attestations that in the ordering clinician’s judgment the patient cannot be cared for in a lower cost setting.
 - iv. Requiring the use of clinical “indicators” developed from empirical claims and assessment data to assist or guide ordering clinicians towards lower cost care settings.
 - b. **Financial incentives:**
 - i. Maintaining no or low patient-responsible portions (cost sharing) in higher value settings with directionally higher patient-responsible portions in lower value settings.
 - ii. Making bonus payments to PCPs for better risk adjusted outcomes relative to service utilization.
 - iii. Enabling PCPs to share in the cost savings for their patient populations through ACO or ACO-like mechanisms.
 - iv. Establishing higher payment rates or bonus payments to all providers with demonstrably higher success rates. In other words “value-based purchasing”.
6. **Use Non-Covered Services.** Formal establishment of a Medicare “Waiver” program in which CMS approves the provision of otherwise non-covered services to patients with high case-management risk scores and specific chronic disease states where those services can be shown to reduce the overall costs of care and increase patients’ ability to remain in their homes. This would help avoid the current reality in which physicians and providers *must* choose from list of Medicare covered services those which are the closest fit, even though much lower cost non-covered services could do.
7. **Renovate Home Health Benefit.** Renovate the Medicare home health benefit currently at section 1861m of the SSA to include:
 - a. Bifurcation of the benefit based on patient types, disease states and assessed risk scores. Patients with selected chronic disease states and risk scores would be eligible to receive a bundle of home health services paid on daily rate that varies with acuity. This would work like the hospice benefit, but better because payment rates would be based on disease states and the assessed risk scores. This approach could also be applied to the hospice benefit.

- b. Modify regulations to provide more flexibility regarding home-bound status and skill requirements again based on disease states and risk scores.
- 8. **Renovate Skilled Nursing Facility Benefit.** In like fashion to home health, removing arbitrary barriers such as the 3-day rule in cases where disease states, care management assessments and provider attestations indicate temporary exacerbations can be more efficiently managed through initial admission into the SNF setting rather than the current requirement to first route the patient through a high-cost acute care stay.
- 9. **Coordinate Dual-Eligible Benefits.** Coordinate Medicaid Benefits for Dually Eligible patients by transfer of Medicaid funds into the Medicare benefit for chronically ill patients much like the SLMB and QMB programs currently function. Require dually-eligible patients to use the same care management provider for Medicaid services that the patient selects for Medicare services in our chronic care proposal. Medicaid programs would be required to make all claims data available to the Medicare program to facilitate coordination. This would allow the care management provider to assist the patient in the coordination of benefits.

ACOs Provide Valuable Lessons and Opportunities

Accountable care organizations are demonstrating that home health and hospice services lower total Medicare spending. ACOs also provide a vehicle to address the objections of some policymakers to our policy proposals outlined above.

While ACOs are still in the early stages of development, we remain very positive with regard to their potential for long-term success. We believe integrating our patient-centric conceptual approach into the existing ACO framework would be of great value for Medicare, for beneficiaries and for taxpayers. Through our Imperium subsidiary, which currently manages 15 ACOs with over 125,000 lives, we now know increased used of home health and hospice services has a high correlation with a decrease in both total PAC spending and total Medicare spending. We encourage the Committee to consider this information as it continues its work.

Thank You for the Opportunity to be Heard

We at Almost Family embrace our responsibility as corporate and individual citizens to advocate for the needs of America's seniors and to work with you to evolve good policies and legislation that protect and strengthen the promise of Medicare for America's seniors and for future generations. We thank you for the opportunity to be heard and to be included as part of the solution. We look forward to working with you in more detail in the evolution of these ideas.

On Behalf of Almost Family, Inc.,



C. Steven Guenther

President

Chairman TIBERI. Thank you.
Dr. Worsowicz.

**STATEMENT OF GREGORY M. WORSOWICZ, M.D., M.B.A.,
PRESIDENT, AMERICAN ACADEMY OF PHYSICAL MEDICINE
AND REHABILITATION, ROSEMONT, ILLINOIS**

Dr. WORSOWICZ. Thank you, Subcommittee Chair Tiberi and Ranking Member McDermott and Members of the Subcommittee.

While I thank you for this opportunity, I hope we are on what I hope will be a continuous evolution of quality improvement under Part A Medicare. We need to treat the best way we can the patients you serve and that I serve together.

I will focus my remarks on improving quality and value-based purchasing in post-acute.

For background, currently I am a physiatrist, which is a physician that works in physical medicine and rehab. I am currently the President of the American Academy of Physical Medicine and Rehabilitation, which is a group of 9,000 physicians trained in my specialty working with people with impairments to be at their most independent and fulfilling function with the right medical and functional rehabilitative components.

Like many physiatrists, I work in many, many settings. Currently, I am the Chair of the Physical Medicine and Rehabilitation Department at the University of Missouri. I am also Medical Director of Rusk Rehabilitation Center, which is a joint venture between our university and HealthSouth, and Medical Director of our post-acute care initiative at the university.

Physiatrists are well-suited to help direct patients to the right level of care. I have worked in all four settings: In-patient rehabilitation, skilled nursing facilities, acute care hospitals, and long-term acute care centers. I have also served on the board of a home health organization.

If you are depending on the patient, you have to understand these patients are fluid that we serve. Take a patient with a stroke. We have evidence-based guidelines that stroke care needs to be coordinated, needs to be comprehensive, and needs to involve the family and other team members. I can take the same stroke patient and, based on their evaluation, the in-patient rehab facility is the best. Another patient with other factors, including their medical, functional, social—I appreciate the socioeconomic factor—the geographic area where they live and the patient choice, and treat them in a skilled nursing facility. Other patients might be treated directly at home with home health. I encourage you to take these factors into consideration as we move forward with legislation.

In fact, I appreciate what Ms. Gage said. Post-acute care starts in the acute care hospital. If we don't place the patient and make that evaluation in the acute hospital, our post-acute programs are bound to fail.

While I appreciate that our academy does strongly support value-based purchasing, I can always say quality had been a focus, but not until there was a financial incentive have I seen that laser-beam focus on readmissions, on hiring people to focus on these issues. So I applaud you on that. I think that is a critical component, and I can attest to that personally.

I will ask, though, that, as we build this focus, realize we have a lot of different programs. I am just a mere clinician out in the field treating patients. I have MACRA, I have MIPS, I have alternative payment models, all these things, and, believe it or not, I actually have to keep up on medicine to care for patients. I would ask you, whatever programs we put in place, we coordinate them; we don't sub-optimize what we are doing and restrict, as with so many regulatory issues I am hamstrung on what I can do or I am chasing incentives that may not align with others.

Withholds I appreciate. Coming from a small, rural area, I will ask, carefully consider what are the withholds and how you put them into play. I would be concerned that if our small-margin centers, if they take too much of a withhold initially, is that an access issue if they go out of business? I am for quality, but I am also for having the access for my patients and giving time to make adjustments.

When dealing with Medicare spending per beneficiary—once again, I can go back to the cost and quality. We have already seen what it has done. I am in favor of this as one metric but not as a standalone metric. I think we do need to have risk-adjusted metrics, looking at function, looking at activity levels for patients, so we purchase wisely the services that we are purchasing for our beneficiaries.

I was asked to talk about some regulatory relief for physicians. Some of that can be just straight administrative paperwork issues. Also, as well, having timing of when things are signed may allow some regulatory relief; and the utilization of non-physician providers, care extenders, or physician extenders to do some of the work that we need to get done.

Last is to work on those deadlines. I would be remiss if I didn't say this. I know 2015 was the year of physician reform. And 2016 is now looking at facility reform. I would ask, in 2017, for some GME reform. If we don't train providers in these settings, how can I or any provider in the future work within these settings effectively?

With that, I thank you. I appreciate the fact that this is a true team of legislative, physician, researchers, and administrators working together to make the best for the patients we serve. Thank you.

[The prepared statement of Dr. Worsowicz follows:]



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Testimony of

GREGORY M. WORSOWICZ, M.D., M.B.A.

On behalf of the
 American Academy of Physical Medicine and Rehabilitation
 (AAPM&R)

Before the Ways and Means Health Subcommittee
 Committee on Ways & Means
 U.S. House of Representatives

Hearing: "The Evolution of Quality in Medicare Part A"

Wednesday, September 7, 2016
 2:00 PM

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Chairman Brady, Subcommittee Chairman Tiberi, Ranking Member McDermott, and
 Members of the Subcommittee:

It is a great honor to testify before the House Ways and Means Health Subcommittee today on the evolution of quality under Part A of the Medicare program. As a physician, I strive every day to find ways to improve the quality of care that I and my clinical colleagues provide to all patients. There are many strategies to achieve improvements in quality and, ultimately, better patient outcomes while providing care in the most efficient manner possible. I intend to focus my comments on payment reform measures and value based purchasing (VBP) in the post-acute care (PAC) sector, topics this subcommittee may consider in the future based on legislation already introduced to this committee.



By way of introduction, I am a board-certified physiatrist, a physician who specializes in physical medicine and rehabilitation (PM&R). I serve as Chairman and Professor of Clinical PM&R at the University of Missouri School of Medicine; the Medical Director of Rusk Rehabilitation Center, LLC, in Columbia Missouri, a joint venture between the University of Missouri and HealthSouth Corporation, and have worked in New Jersey, Florida, Texas, and Missouri in a number of health care settings including inpatient rehabilitation hospitals, skilled nursing facilities, long term acute care hospitals, and acute care hospitals. I have also served on the board of a home health agency. I am currently President of the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and testify today on their behalf.

AAPM&R is a national medical society representing more than 9,000 physiatrists who 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 primarily receive their training in inpatient rehabilitation hospitals and units (IRFs) but work across the entire post-acute care continuum. 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. The notion that these PAC settings provide the same services, treat the same patients, and achieve the same outcomes is simply not correct and several recent studies have demonstrated this.¹

The goal is to provide the right level of medical and rehabilitative care at the right time: to match the medical, functional, and situational circumstances of each patient with the level of rehabilitation intensity, coordination of care, and comprehensiveness that each PAC setting provides. In many instances, the decision to treat a patient in a particular PAC setting is relatively clear. In those instances, when it is not, clinical judgment plays a major role in the selection of the appropriate PAC setting based on the patient's medical and functional needs, and taking into account the totality of the patient's situation, including the potential to live independently, with or without family and other support systems.

¹ Buntin MB, et al. *Med Care*. 2010; 48(9): 776-784 (Retrospective review of 287,115 Medicare patients; IRF patients have lower mortality, greater return to community); Wang H, et al. *PMR* 2011;3(8): 686-694 2011 (Retrospective review of 33,000 patients under Kaiser system; IRF patients had lower mortality than SNF); Deutsch A, *Arch Phys Med Rehabil*. 2013; 94(4): 630-632. (Retrospective review of 58,724 patients (pre-PPS – 1997); IRF patients with higher FIM motor scores and more community discharges).

For instance, in my practice, I routinely treat Medicare patients who have experienced a stroke, an injury to the brain resulting from restricted blood flow. Patients with stroke present with a wide variety of medical and functional needs, from limb paralysis or weakness, to difficulty with speech, to complications with vision, balance, cognitive function, coordination and other physical impairments. Occasionally, the decision to admit the patient to either an IRF or a SNF is not clear. Ultimately, the physician and the rehabilitation team must make a decision based on an assessment of the patient and the medical record, the patient's acuity, the assessed functional deficits, the patient's age, medical history, comorbid conditions, level of function prior to injury, the potential to improve function, the potential to return home to independent living, the level of family and other supports, and, of course, the patient's preferences and goals.

Depending on the severity of a stroke, patients could conceivably be referred to any one of the four PAC settings. It is critical that the patient who needs a particular intensity and level of coordination of rehabilitative care does not get diverted into a sub-optimal PAC setting. The patient must be stable enough to engage in the appropriate intensity of therapy while the patient's medical condition is managed by the physician based on the patient's individual needs. Best practices for stroke treatment was the subject of a set of important stroke guidelines recently published by the American Heart Association/American Stroke Association and endorsed by the AAPM&R entitled, *Guidelines for Adult Stroke Rehabilitation and Recovery*.²

This heavily footnoted study concluded that, "Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient and his or her goals, family and friends, [and] other caregivers..." The guidelines also state, "Communication and coordination among these team members are paramount in maximizing the effectiveness and efficiency of rehabilitation and underlie this entire guideline.... The provision of comprehensive rehabilitation programs with adequate resources, dose, and duration is an essential aspect of stroke care and should be a priority in these [health care reform] redesign efforts."³

² Winsten CJ, Stein J, Arena R, Bates B, Chertney LR, Cramer SC, Denryter F, Eng JJ, Fisher B, Harvey RL, Lang CE, MacKay-Lyons M, Ottenbacher KJ, Pugh S, Reeves MJ, Richards LG, Stiers W, Zorowitz RD; on behalf of the American Heart Association Stroke Council, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. *Stroke*. 2016;47: e98-e169. DOI: 10.1161/STR.0000000000000098.

³ *Ibid*, at page 142.



This is the type of care that is consistent with the level of rehabilitation provided in an IRF. While SNF care for some stroke patients is completely appropriate, patients in need of an intensive, coordinated stroke rehabilitation program provided by an interdisciplinary team must continue to have access to this level of care. As Congress and CMS implement reforms to improve quality and save resources in the future, they must not inadvertently erect barriers to patient access to the appropriate course of treatment and setting of post-acute care.

Improving the Quality of Post-Acute Care

As the national policy goal of paying for value rather than volume continues to shape the health care system, many strategies are being pursued to improve patient outcomes and quality while reducing the cost of care. The level of change and innovation to achieve this goal is unprecedented as CMS implements and oversees multiple shared savings programs, Accountable Care Organizations (ACOs), pioneer ACO's, the Bundled Payments for Care Improvement (BCPI) initiative, Medicare Advantage, the Comprehensive Care for Joint Replacement (CJR) mandatory bundling program, the proposed cardiac care bundling program, as well as value-based programs such as the CMS Hospital Value-Based Purchasing program, and the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs) under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Despite this extensive transformation in the way Medicare pays for and providers deliver care, the data that demonstrate whether these many different programs are meeting expectations and achieving their goals are only beginning to become available. The most important impact of these programs—the patients' experience with and outcomes from care—is simply not known in any reliable or consistent manner at present. For physicians, this is particularly true with respect to the value-based payment systems (i.e., MIPS and APMs). While physicians will be subject to withholdings and incentive payments based on quality measures over the coming years, the Academy cannot speak with experience about the impact it will have on the ability to deliver care or the ultimate outcomes of patients; unfortunately, nor can CMS.

In the MACRA rule published in May of this year, CMS discussed the impact of incentive payments on physicians at levels currently being debated. CMS stated, "We have not attempted to quantify the benefits of this rule because of the many uncertainties as to both *provider behaviors* and resulting effects on *patient health* and cost reductions. For example, the applicable percentage for MIPS incentives changes over time, increasing from 4 percent in 2019 to 9 percent in 2022 and subsequent



years, and we are unable to estimate precisely how physicians will respond to the increasing incentives.¹⁴ [Emphasis added.]

Post-acute care alone is in the midst of one of the most active regulatory stages in its history. Coupled with the value-based programs cited above, the pace of change in all four settings of PAC services is breathtaking. It presents significant challenges for providers in keeping abreast of, and adapting to, these changes which are primarily focused on quality improvement. 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 preserves patient access to the right setting of care at the right time.

In the past year alone, AAPM&R, and all PAC stakeholders including patient organizations, have had to address, interpret and comment on numerous regulatory and sub-regulatory proposals related to quality improvement. A summary of the most notable developments include the following: (1) the annual prospective payment system regulation for LTACHs, IRFs, SNFs, and HHAs which have included implementation of IMPACT-mandated quality measures in each setting; (2) National Quality Forum deliberation of many of those same quality measures; (3) announcements of draft quality measures and Technical Expert Panels (TEPs) on IMPACT-mandated measures across PAC settings, often with accelerated comment periods; (4) proposed standardized assessment-based data elements under the IMPACT Act; and (5) the annual physician fee schedule proposed rule for FY 2017.

In addition, each PAC setting is in the midst of adapting to the ICD-10 coding system, considering the implications of an IMPACT-mandated report by the Medicare Payment Advisory Commission (MedPAC) on the development of a unified PAC payment system, and grappling with implementation in several key states of a new home health "pre-claim review" procedure. In short, the capacity and ability of the PAC community to adapt to additional changes at this time is limited.

Value-Based Purchasing for Post-Acute Care

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

¹⁴ Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Fed. Reg. 81, No. 89 (May 9, 2016), at 28377.



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, should be rejected. Stinting on patient care is the AAPM&R's primary concern with all shared savings programs, delivery models, and payment reforms. Because of this we have made public our concerns on various models of post-acute care reform and various proposed pieces of legislation and offer some comment of key components of quality incentive programs and payment reform proposals.

1. Timing: We believe passage of this legislation 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.
2. 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.
3. Withhold Is Too High: The Academy has concerns if withholds are too high in any program if may create significant risks that some post-acute care providers may be forced to close their doors, risking access to care, especially in rural settings and in urban areas. These providers are more likely to already be struggling due to a variety of factors and a significant payment disruption could be too difficult to overcome. Financial incentives to improve quality must be designed to motivate provider behavior without undercutting the financial viability of a significant percentage of providers who serve rehabilitation patients in their respective communities.

Reforms centered on financial incentives must be based on a strong financial foundation. The fact that some of the other Medicare VBP programs use carefully developed percentages to reward or penalize providers does not mean



that these same percentages should apply to post-acute care. Meeting the post-acute care needs of Medicare beneficiaries with injuries, illnesses, disabilities and chronic conditions entails many variables not present in many other health care settings. This dictates independent policy development around a PAC VBP program. We note that the Hospital VBP program withholds no more than 2 percent of Medicare payments and request the Subcommittee to consider this withhold as a template for PAC VBP.

4. **MSPB:** Medicare Spending Per Beneficiary (MSPB) 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.

5. **Functional Measures and Quality of Life:** 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 of 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) versus 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.



6. **Budget Neutrality:** AAPM&R believes that in addition to the withheld funds that form the pool of incentive payments, that any future consideration of PAC VBP legislation should reinvest any savings from the program back into the PAC system of care. This funding could be used to implement common-sense reforms in the various PAC settings to help further improve care, lessen provider burden, streamline unnecessary paperwork, and enhance access to patient care.

Regulatory Relief for Physicians in PAC Settings

Given the Academy's concern with moving forward with PAC reform legislation on such an accelerated timeframe, it may be perceived as premature to discuss proposals to include in the bill that would lessen the regulatory burdens facing physicians practicing in PAC settings. But there are numerous proposals that could be pursued, whether through a PAC VBP bill or in another legislative vehicle, that would genuinely make patient care more accessible, reduce regulatory burdens on providers, and not cost much, if anything. We are confident that other PAC stakeholders will offer their own ideas for regulatory relief at the appropriate time, but what follows is a number of regulatory priorities for the Academy that would benefit physicians practicing in PAC settings.

1. **Clarify the "Intensity of Therapy" Requirement in IRFs:** The so-called "Three Hour Rule" should recognize recreational therapy as counting toward satisfaction of the intensity of therapy requirement. Recreational therapy should be counted as one of the skilled therapy modalities allowed under calculation of the Three Hour Rule when these services are prescribed by the treating physician and the rehabilitation team as part of the patient's plan of care, are considered active treatment, and are provided by a qualified recreational therapist. Currently-pending, bipartisan legislation in the House, H.R. 1906, seeks to recognize recreational therapy as an included therapy discipline under the Three Hour Rule. AAPM&R has been a strong champion for this bill, which has the support of a number of key rehabilitation providers and consumer stakeholder organizations. The modification would permit physicians to better manage their rehabilitation therapy teams in providing the appropriate mix of services required by each patient. The proposal is not expected to have a major budget impact.



2. Allow for Physician Extenders: Congress should clarify that physician extenders (e.g., physician assistants and nurse practitioners) who are acting under the supervision of the rehabilitation physicians are permitted to fulfill certain regulatory requirements in a number of PAC settings, as long as concurrence by the physician is documented. This proposal would provide additional capacity for physicians to comply with numerous documentation burdens in PAC settings, enhancing the ability of these physicians to comply with relevant deadlines. Regulatory relief designed to ease the burden of documentation would likely have a material impact on the number of Medicare claims denials based on non-clinical factors. Extending the authority to use physician extenders in this context is consistent with the expanding use of physician extenders across the health care system and would likely have no budgetary impact.
3. Permit Documentation Deadlines to Be Extended: Congress should clarify that Medicare's documentation requirements in PAC settings have some degree of flexibility in order to focus on patient care, first and foremost. For instance, documentation that is required to be signed within a certain timeframe should be permitted to be completed by noon of the next business day if the original deadline falls on a weekend or federal holiday if it does not directly impact patient care. This provides greater flexibility in the documentation deadlines, within reason, and would likely lead to greater work satisfaction levels among physicians and other rehabilitation professionals in multiple PAC settings, as well as fewer denials for documentation that contains technical deficiencies.
4. Other Policy Proposals for the Subcommittees' Consideration: The Academy has other regulatory relief proposals that it would like to discuss with the subcommittee as it continues to debate post-acute care reforms, including clarifying the rehabilitation physician's role in IRFs and other settings of post-acute care, as well as funding for Graduate Medical Education (GME) training across all PAC settings.

Thank you for the opportunity to testify on this important set of policy issues confronting the subcommittee. The American Academy of Physical Medicine and Rehabilitation stands ready to assist the subcommittee as it continues its important work on quality improvement in the area of Medicare post-acute care.

Chairman TIBERI. Thank you.

All four of you provided some really good testimony. We really appreciate it.

If each of you could put yourself in our shoes, what three principles would you name as we try to legislate pay-for-performance? Think about three principles that we could use in legislating that issue.

Ms. Gage.

Ms. GAGE. Three principles. Well, one principle that has underlined a lot of the past work—you know, I work in the post-acute care payment arena and quality measures development, and having equitable payment rates is critical to having a cost-effective use of the Trust Fund. That said, equitable payment rates are only equitable if the patients are equivalent. So understanding the outcomes is key to any payment modification.

A second principle is actually tying the quality initiatives to payments. Because, as we have seen and as Dr. Worsowicz mentioned, until readmissions were tied to financial penalties—and we have seen those in each of the programs—there have been QRPs, but they haven't really moved the dial.

And the third principle I think is keeping the patient in mind. Since the ACA passed, we have had a lot of talk about patient-centered care and about the patient's preferences and needs. And all of these patients, at least those that are discharged from the hospital to post-acute care, have a range of complications—medical issues, functional issues, cognitive factors complicating it. So really designing systems that allow for adjustment, given that mix of factors, will ensure access to appropriate services.

Chairman TIBERI. Thank you.

Ms. Wynn.

Ms. WYNN. So the three that I would put forward for your consideration is, one, a program that is streamlined in some way so that providers don't suffer from measure fatigue. In the hospital sector, we are reporting on over 90 different measures now, and we are spending all of our time chasing the measures, and that really detracts from time that could be spent on quality improvement efforts themselves.

A second principle would be to ensure appropriate risk adjustment that really will ensure buy-in from the provider community that the measures are fair.

And then the third, I would say, is to focus on issues that are within the control of the provider so that it really is focused on provider quality as opposed to other issues in the community.

Chairman TIBERI. Thank you.

Mr. GUENTHNER. So I think, from our perspective, first, patients matter more than providers. We always have to keep that. There we go.

Chairman TIBERI. Thank you.

Mr. GUENTHNER. My first item is patients matter more than providers. We have to design processes and systems that address the needs of patients. And we really need to be talking much more about how we do that than about how we pay individual provider categories.

Number two, with all deference, hospitals are incredibly important; health care does not begin when you get admitted to a hospital. Health care begins in the patient's home, and it ends in the patient's home. And I know we have some statutory things going on around that, about what a spell of illness is and how it only begins when an in-patient admission begins. We take huge exception to that and would love to see this much more focused around where the patient needs to be.

Number three is around value. And value is not an item; value is a relationship. Value is the relationship between the quality and the cost to produce that quality.

Chairman TIBERI. Thank you.

Dr. WORSOWICZ. I agree, care is not a building, it is not bricks and mortar, it is a process. No matter where this process happens, the key is to get what the patient needs servicewise to them. And we have built these silos. Think about process.

Second is quality and function. Function is part of quality. Remember that. We have to have that.

Third is payment. When you look at payment, think, what is the long-term ROI? Is the patient at home, not in a facility? Is the patient able to return to work, now a taxpayer? Is the patient able to do enough that their loved one isn't out of work caring for them?

So when we talk about pay and money, what is the long term on it? We have bundled payments. Is it 30 days? Is it 60 days? Is it 90 days? Is it 2 years? The issue is, what is it? I don't know.

Chairman TIBERI. So one more question for all of you, kind of along the theme that you all have been discussing. We all share this idea of the best quality at the lowest possible cost to Medicare and its patients.

CMS gathers all this information from all of you. We have access to it, you have access to it, CMS has access to it. Some of my family members who are on Medicare, they don't have access to it. So if someone has a stroke and needs to go to a rehab facility, how do they measure quality? How do they measure cost? How do we get them engaged and their family, me, to understand, as a loved one, what is best for them and their needs? How do we make that connection?

Ms. Gage.

Ms. GAGE. Having worn those shoes, despite being a researcher, those are very difficult questions.

The easy answer is one could go to the CMS website and look at the hospital compare and the SNF compare, et cetera, to see whether the organizations in your community have decent quality ratings based on the composites of the measures that are there.

Alternatively, speaking with your physician and the people that you know and trust is another major source of information. But often we don't really know what to look at. We don't know that nursing ratios are actually quite important, we don't know that if someone isn't turned they could end up stroking in the hospital. So it is a very complicated issue.

I think CMS has done a lot over the last 5 years to engage stakeholders, to bring them to the table. Some of the work that I am doing with them is trying to identify stakeholder preferences. What would they like to see incorporated in exchangeable information?

What would they like to know when their loved one goes home from the hospital? What is important? And some of those factors have nothing to do with insurance coverage. Some of them are having food in the fridge so you don't end up back in the hospital dehydrated.

So it is a tough area.

Chairman TIBERI. Thank you.

Ms. Wynn.

Ms. WYNN. I would agree with Dr. Gage. And I would just add that I think we are really at almost kind of a nascent stage in being able to pull together the information on quality, on cost, on other factors that policymakers may be interested in, but getting at the heart of what the patient is interested in and patient preference. Working with the physician to identify what is the appropriate care setting for them to be discharged into, is that a SNF or is that home care, based on their own, you know, circumstances and the home supports that may be available to them.

And I think the other area in which a lot of work is going on right now is on improving the communication channels between the different silos within the provider sectors. So as the patient transitions from whether it is a hospital to a rehab facility or rehab to SNF, ensuring that the hospitals, the nursing homes, the home health agencies, and the rehab providers understand what the capacity is at that next level of care to care for the patient, so that we make sure that patients are really discharged to that appropriate care setting.

Chairman TIBERI. Thanks.

Mr. GUENTHNER. Not to oversimplify this, but I think the best way to find out what is important to beneficiaries is to ask them. And I am really confident that the average Medicare beneficiary, when they have an exacerbation or acute care episode, is exceptionally interested in restoring their level of functionality and getting home.

Chairman TIBERI. Can I interrupt you, though?

Mr. GUENTHNER. Yes, sir.

Chairman TIBERI. Here's what I mean. So my mother-in-law has a stroke. She is in a hospital. She is going to be discharged from the hospital. The doctor says she has to go to a rehab facility. How do you choose the rehab facility?

Mr. GUENTHNER. I think, in our view, in that situation, the key to this is to get in front of that disease state. I think when the patient, particularly a Medicare patient, who is aged, is in an unhappy place because their illness has progressed, they have waited too late to begin to think about engagement in their own care. We have to get in front of these disease states.

We have to get in front of every chronic disease state that we can and engage the beneficiary in advance of that stroke, in advance of that acute care episode. Because, at that point, with the clinical illness, the cognitive implications, frankly the depression, which is a major factor in illnesses in the elderly, that goes along with it—if you think about this in the context of your mother or your grandmother, what do they want? They want their life back.

Now, they may not get it back because their disease state may not let them get it back. But if they can't get their life back, then

they are going to want the best quality of life that they can get to deal with their disease state.

And we shouldn't rely on my testimony to answer that question. We should find that answer. And we should have some process to engage beneficiaries, the patients themselves, before their disease state advances, so that we can make sure we have a good measure of that.

Dr. WORSOWICZ. I am happy to talk with you afterward about your mother-in-law to help guide you. First of all, I hope she has a physiatrist that is seeing her to help with it.

But you are right on. This is what I do every day. I see people in the acute care hospitals, and they say, I want to go to the best place, I want to get the best there is, and, of course, they listen to me because they trust me. I am that good—no. Actually, you are exactly right. That is what perplexes us everywhere.

First, I think the area of care coordination needs to be driven home. Because you may go to a skilled nursing facility at that point in time and it is the best for you because you can't take the physiologic stress of 3 hours of therapy and I could cause harm to you by sending you to the IRF at that point. It is the same as if you go to the IRF, do the skilled nursing. We are still siloed on coordinated care. You need to incentivize to coordinate that post-acute care for your mother-in-law. And if she doesn't go to the right place the first time, we are incentivized to do the right thing by her.

Second, you are taking a big leap of faith if you think the providers in an acute care hospital know the quality of where they are sending people. That is a big factor. I can tell you they don't. That is why you have 8 million different liaisons in hospitals saying, we are the best, we are the best, we are the best. We need to develop risk-adjusted metrics and scorecards so I can grade you to know that, hey, we are sending her to the best.

Third, your mother-in-law just had a stroke; you are not going to hear one-tenth of anything I tell you. So remember that.

We have to work on those systems. Coordinate the care first, build that in. Second, let's develop scorecards or a way to meaningfully measure the care you get. And I would also not think that every IRF is the same. Every SNF is not the same. You have a wide variety of services. So I could send you to one versus another and get totally different doses of therapy, doses of medical coverage, doses of social care.

If we had 3 hours—I will talk to you later, but—

Chairman TIBERI. Yeah, we have an opening on our staff for a doctor. We would love to have you apply.

Dr. WORSOWICZ. Yeah, there you go.

Chairman TIBERI. Thank you all.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to change the focus here just a little bit.

Ms. Gage, do you have an advance directive?

Ms. GAGE. Do I have to admit this publicly?

Mr. MCDERMOTT. You don't.

Ms. GAGE. I have no children, though.

Mr. MCDERMOTT. Ms. Wynn, do you have an advance directive?

Ms. WYNN. I do not.

Mr. MCDERMOTT. Mr. Guenthner.

Mr. GUENTHNER. No, sir.

Mr. MCDERMOTT. So all four of you—

Dr. WORSOWICZ. I do. Yes, sir.

Mr. MCDERMOTT. You do?

Dr. WORSOWICZ. Yes. And my wife has a pillow too.

Mr. MCDERMOTT. All right.

Now, the reason I raise this issue is that we all know that about 70 percent of healthcare costs occur in the last 6 months of life. You can argue about the figures exactly, but that is sort of roughly what we have been able to put together.

And Mr. Guenthner talks about listening to the patient and what does the patient want and so forth. And what I have trouble putting together in my mind is, how much do you think having an advance directive or lack of an advance directive plays into the kind of care that a physician or whatever provider puts forward?

I mean, how often does somebody look at those advance directives and say, this is what they want, and we are trying to get them over to here, but they are never going to get there, they are probably going to get over here. And maybe they don't want us to try to get them over to there, which is 100 percent or 70 percent. As you say, you can put them into a care situation and give them 5 hours of therapy a day and wind up with a patient who says, God, leave me alone, I feel rotten.

So how does the advance directive play into that? Mr. Blumenauer put through a bill, Mr. Levin and I put a bill in 25 years ago, that everybody in Medicare ought to file an advance directive, but we have never gotten above 20 percent of the population. And we are about there today, with three out of four not having one. That is sort of reflective of America, where we don't get people to write wills either. But advance directives are even lower than writing wills.

So how can you develop care—the physicians, how can they deliver care when they don't know what the patients want?

Ms. GAGE. I am not a physician, but I have worked on some of the issues. The Joint Commission for Hospitals had directed the inclusion of the identification of whether somebody had information in their chart on their wishes or their surrogate wishes, and CMS has worked that data element into some of the assessment tools.

That said, as a daughter-in-law, I have seen that we have our wishes, sometimes we left them at home in the living room, sometimes they are in the chart. You come into the emergency room; the doctor does all that is possible regardless of what is in the chart.

So advance care directives appear to be a sensible approach, but I am not sure they are the most effective way of communicating patient wishes.

Mr. MCDERMOTT. So you are really suggesting that doctors should be the final deciders of everything. They have the power. You are there, you put yourselves in their hands. I mean, having been a physician, I realize people come in, say, here, take care of me. And that is what you are saying.

Ms. GAGE. I am not saying that that is a measure of quality or an ideal situation. I think that is the experience that happens quite frequently.

Mr. MCDERMOTT. It is not what happens in Mr. Kind's district, where about 80 percent of the people have advance directives, because there was a concentrated effort by the medical community to do that.

Doctor.

Dr. WORSOWICZ. Yes. Actually, with the type of work I do, the advance directive only comes into play with severely brain-injured patients and severe stroke patients. Otherwise, it is what does the patient want and what is the goal.

Part of my goal is to describe to them what the physiologic capacity is to meet that functional goal and the impairment that they have and how they would attain that goal. I don't disagree with you at all. We tend to spend a ton of money at the end of life. I want to spend a ton of money to preserve quality of life, is what I am working on.

So, in my practice, advance directives come into play only in those severe cases and when they don't maybe have a health surrogate.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman TIBERI. Thank you, Mr. McDermott.

Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman.

I just have two quick questions.

Dr. Worsowicz, could you give me a sense of how the IMPACT Act interacts with any subsequent proposals to make changes in this area?

Let me give you the backstory on my question. I had a meeting with folks in my constituency, and they are concerned and they say, look at the IMPACT Act. The data has yet to be determined or yet to be collected or whatever, there is some that has not yet happened, and now something new is being contemplated. And, you know, they didn't say it this way, but what they are telling me is, hey, cut us some slack here, you know?

And I don't know enough off the top of my head about how these things interact. Are they over-characterizing that? Are they characterizing that accurately? Is there a legitimate beef? What is your perspective?

Dr. WORSOWICZ. I imagine you get both ends of the spectrum that walk into your office, yes/no, yes/no. Some of the scientific data from the IMPACT Act—I will ask my panelists—is yet to be fully developed to say what has been—have we moved the needle to where we want to move the needle.

Mr. ROSKAM. So is the data already being collected on the IMPACT Act, just so I am clear?

And anybody else from the panel, can you just educate me on that?

Dr. WORSOWICZ. I will let the experts.

Ms. GAGE. Some of the concepts that were in the IMPACT Act are being collected currently. They were moved right into the assessment tools in each of the different settings.

Mr. ROSKAM. So folks who were in talking to me, what were they referring to that is going to happen next month? Do you know off the top of your head?

Ms. GAGE. There is ongoing work to continue development of additional items.

Mr. ROSKAM. Okay.

Ms. GAGE. And that work is—well, there are different timelines going on depending upon whether they were talking to somebody about quality measures or data element development. But, this month, the first pilot test went live with some of the additional measures in the IMPACT Act. But CMS had already moved forward some of the directives from the original set.

There are about four or six different conceptual domains. And so moving items in right away—for example, function is now in a standard way collected in the rehab hospitals, the SNFs, the home health, the LTACs. But the other metrics that you might want to use that might also be in the area of function are still possibly under development. Certainly, in the area of cognition, there is additional work being done.

Mr. ROSKAM. Okay. That is helpful. Thank you both.

Ms. Wynn, do you have a sense, you know, being active with the Hospital Association and so forth, are there some regulatory trade-offs that CMS or Congress could offer that are reasonable, that make sense, that don't jeopardize patient safety, you know, et cetera, et cetera, et cetera, that are just good commonsense things that your members would say, look, we can live with this change in reimbursement if you cut us some slack over here? Do you follow my question?

Ms. WYNN. Yes, sure. So there are several different areas. One I would offer, especially as we move toward value-based payments where the providers are taking the risk, is on medical necessity review, so chart reviews. They are very administratively burdensome on the hospitals to provide the paperwork to the reviewers, and we commonly have disagreements with the reviewers—

Mr. ROSKAM. I get it. So the argument is, look, we are assuming the risk here; what is this whole review process?

Ms. WYNN. Right. So if we are taking the risk for the total cost of care of a Medicare beneficiary, then it is up to us to decide whether or not there should be an in-patient admission or whether or not they should be treated in an ambulatory care setting. Let us decide the best place for the patient.

Mr. ROSKAM. That makes perfect sense to me right now.

Has that largely been socialized? Are more people talking about this than I realize? Is this one of those things everybody is talking about and I just don't know it?

Ms. WYNN. Certainly within the hospital community we are.

Mr. ROSKAM. Okay. That is helpful.

Okay. Thank you.

Thanks, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you.

Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

I was interested in the discussion as it went along regarding patients in the mix. And somebody said that there should be a finan-

cial penalty for readmissions. Mr. Guenthner, I would like to hear from you on what responsibility does the patient have in this.

One thing I hear from my providers is they do everything they need to do on their end, they send them home, and then they don't do what they are supposed to do, they come back, and the hospital gets dinged.

Mr. GUENTHNER. Okay. I might have finally figured out the microphone.

So, you know, I think that patient compliance is always an issue in medicine. We see it in home care. We go into the patient's home, we make the assessment, we give the advice, and patients don't follow it. And this is America; patients don't have to follow it. And sometimes they can, and sometimes they don't.

We think that—again, I sound a little bit like a broken record, but the trick is to get in front of the high-risk patient's chronic conditions and to engage before the acute care episode happens to see if we can get closer.

Mr. THOMPSON. That may work well in some communities, in some populations, but in others it doesn't. How do you crack that nut?

Mr. GUENTHNER. If you could expand just a little on those that you are concerned about where it doesn't work.

Mr. THOMPSON. If you have a community that is maybe not as inclined to follow healthy procedures or a community that doesn't have access to quality food, for example.

Mr. GUENTHNER. Okay. So one of the places we see this in our practice is, in particular, with the dual-eligible population, where income levels tend to be lower, education levels tend to be lower, and there are more socioeconomic issues going on in that community.

And one of the things that we have talked about in some of our previous submissions to the Committee is the need to really get at that coordination of benefits with the dual-eligibles and to bring some of these socioeconomic factors into play. We can't always—

Mr. THOMPSON. I don't know if we are going to figure it out today, but I think that is something that needs to be in the mix, because I don't think you can put the whole load on the provider. We need to figure out how to either get every population to do what they are supposed to do—

Mr. GUENTHNER. Right.

Mr. THOMPSON [continuing]. Or figure out how to mitigate that financial penalty.

One area that I think is interesting—and this whole VBP is based on delivery of appropriate care faster and more efficiently. And with the advances in diagnostic testing, I think we have an ability to be able to bring diagnostics into the mix to help speed that up.

And I guess, Ms. Gage, I would like to know, what do you think we should do to make sure that hospitals and other providers are using the types of advanced technology that will really drive all the outcomes?

Ms. GAGE. Hospitals are receiving some incentives at this time with the movement toward ACOs and bundled payments and value-based purchasing programs where the market is now giving

them the incentive to have the best technology available. Some of the hospitals are starting to move into telemedicine, even though it is an unfunded Medicare benefit. And I think we are seeing some changes in the market in response to achieving the best outcomes. Competition is starting to drive what is delivered on an outcome basis.

Mr. THOMPSON. And you hit on the other thing I was going to ask about, and that is telemedicine. I have been involved in that for a long time. And it hasn't been necessarily beneficial in the fee-for-service landscape, but I think it fits well into value-based purchasing.

And, Ms. Wynn, do you see a potential for growth in telemedicine under the VBP model? And is there anything we should be doing to enhance that?

Ms. WYNN. Sure. Thank you for the question.

We are seeing, you know, telemedicine I think historically has been thought of as more of a presence in the rural areas, and we are starting to see more and more of our members in inner city urban areas using telemedicine to provide specialist care and ensuring access to those higher acuity services for patients. So I think payment policies that can continue to enhance those services would be one thing, and then that is another area for regulatory review as well.

Mr. THOMPSON. Well, I would submit that not only does it work well in underserved areas, you know, rural or urban underserved, but I think there is potential benefit if we were able to grow this delivery of medicine and use it more and figure out how to make it work to provide you guys the opportunity.

Thank you, Mr. Chairman.

Chairman TIBERI. Thank you.

Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman.

Thank you to our panel today. I appreciate your dedication to these issues that are certainly important that we ensure dollars are well spent on quality care, and I appreciate your expertise.

Ms. Wynn, providers often site Medicare's conditions of participation as being outdated and burdensome. Which of these requirements would you say are most problematic for hospitals?

Ms. WYNN. I think I would follow up with your staff on those issues.

Mr. SMITH. Okay. I appreciate that. I know there are a lot of issues here, and I know certainly observing the various situations over the last several years, my own grandmother, for example, I am glad there are some great providers out there and facilities that they will look to to offer great services.

Thank you, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you.

Mr. Davis, you are recognized for 5 minutes.

Mr. DAVIS. Thank you. Thank you very much, Mr. Chairman.

I certainly appreciate this hearing, and I thank all of the witnesses for being here.

We have talked a bit about safety net institutions and population groups that might frequent them. And as we move toward standardizing treatment, as we attempt to standardize payments, let me

ask you, Ms. Wynn, how do we make sure or try to make sure that we are treating the safety net institutions fairly?

And I know that fairness is like beauty, in the eye of the beholder, but how do we try to do that?

Ms. WYNN. I think the most important thing is making sure, especially in payment penalty programs, that the measures are risk-adjusted to recognize the socioeconomic issues and sociodemographic issues that are facing the patients so that those hospitals aren't unfairly held accountable for some of the patient factors.

The second thing is making sure that the supplemental payments, or DSH payments, are paid to the providers. They are critically important, whether they are Medicare payments or Medicaid payments, to really the financial viability of the financial institutions. The ACA included some very significant cuts in funding in those programs, and, you know, as a representative of many of those institutions, that is an area that we are very concerned about as we look forward over the next few years, is maintaining those funds so that our hospitals can maintain their operations and access to services for the communities you are discussing.

Mr. DAVIS. Let me just ask if other members of the panel would like to comment on that question?

Dr. WORSOWICZ. I think the risk adjustment is critical. I think some of the DSH payments, I am not as positive. Make sure the post-acute care providers that care for these individuals have the risk adjustment. The key is to have the payment follow the patient in these areas.

We brought up the other issues of being big on the use of technology, of using telehealth. Make sure that people are able to be provided their medicine as they go home and that they get instruction in the home place.

I would argue, if you have a family member, an elderly family member, ask them for their med list. There is no way they can understand their med list, even if I were to spend an hour and a half going over it. So we need to put in some safety net procedures to assist them once they leave the hospital into either the hospital setting, the skilled nursing setting, or the rehab setting to make sure that is following them.

Mr. GUENTHNER. I think my answer to that, Congressman, really gets back to the need to coordinate benefits between title 18 and title 19 of the Social Security Act. Patients, if they, in fact, are safety net patients, don't understand the difference between Medicare and Medicaid and don't care about the difference between Medicare and Medicaid. They believe that their government, the promise made by all of us to care for these patient populations, is going to handle it and there is going to be folks looking out for them.

And it really does come down to the need to coordinate care. A lot of providers have to spend a lot of time trying to figure out for a given patient, now, is this a Medicare benefit? Is this a Medicaid benefit? How do I think about that, and how do I coordinate those? And this may be way outside the scope of this Committee's deliberation, but ultimately bringing those benefits together we think is absolutely critical for the future of the healthcare system.

Mr. DAVIS. Ms. Gage.

Ms. GAGE. I think you approach it in terms of the payment design. Typically, the lower income populations have more healthcare complications for whatever reason—the food, the genetics, whatever is behind those differences. And so, as Dr. Worsowicz said, risk-adjusting the outcomes and risk-adjusting the payments, that is one way of correcting for the higher needs of those more severely ill populations.

But, secondly, you raised the issue of the public hospitals and the provider serving the underserved areas. So when you think about a payment system, there are two types of factors at play. There are the case mix factors, where you adjust for the patient differences, but there are also often setting-specific factors that recognize the fixed costs of different types of providers. And those fixed costs are important, because different types of patients need different types of resources. So addressing both of those in a payment design can help.

Mr. DAVIS. Thank you very much, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you.

Ms. Jenkins is recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

And thank all of you on the panel today. Countless studies from universities, health insurers, and MedPAC state that the geographic in costs for Medicare is in the post-acute care setting and that those costs vary a great deal. In my district in Kansas, most of the post-acute care providers are rural, and they are typically low-cost options compared to the national average for care in the post-acute care setting.

There is a section in the Medicare Post-Acute Care Value-Based Purchase Act, 3298, that measures cost at a geographic level.

Given the fact that Kansas is a relatively low-cost rural State, I have just a couple of questions maybe for Mr. Guenthner and Dr. Gage. How will this geographic measure benefit Kansas providers, and how will this bill either negatively or positively impact rural PAC providers?

Ms. GAGE. I hesitate to answer, because I haven't looked at the specific legislation that you are referring to.

Ms. JENKINS. Okay.

Ms. GAGE. But, typically, often there are rural adjustments to recognize the differences in the cost factors in the larger rural areas. They are typically setting-specific. And I am not sure what went into that bill, so—

Mr. GUENTHNER. Well, first, I want to really thank you for this question, because this is a topic of great interest to us. We talked about it in our program integrity proposals, and we see it significantly in our ACOs. We manage 15 Medicare ACOs through our Imperium subsidiary, and there is, in fact, great variation in healthcare spending across the Nation. It is not limited to post-acute care. It is more prominent in post-acute care.

In home care in particular, we see very dramatic differences, really around the supply of providers relative to patient populations. And so when I talked in my oral testimony about the program safeguard idea, that idea is about looking at the relationship of utilization to a patient population. If I was a taxpayer in Kansas, like I am in Kentucky, it disturbs me to see, for example,

3½ times the home care use in one State that I see in another State. And then when I go look at what is causing that and I see the supply providers relative to patient populations—I want to tell you a fact, and you can decide if this makes any sense to you. In Chicago, the metro area, there are 664 home care providers. In New York, the metro area, there are 61. Not surprisingly, home health utilization in Chicago is a lot higher than it is in New York. And this is at the core of how we control variations in utilization pattern. We believe strongly that differences in the supply of providers create different normative standards in a community. Because there are so many providers competing for a number of patients, the definition of medical necessity moves. And what is medically necessary in New York and what is medically necessary in Chicago become different measures, and that is really not how this Medicare benefit should be administered. And thank you for that question.

Ms. JENKINS. Sure.

Is there any other feedback from the panel?

Ms. GAGE. And that is why outcomes measurement is so important. We do see a lot of variation associated with supply, but understanding whether the patient is getting more services because they are more medically complex or more functionally impaired identifies the inappropriate variation.

Ms. JENKINS. Okay. That is very helpful.

Yes.

Dr. WORSOWICZ. They hit on the term “medical necessity.” Be very careful when you use that term. As we have seen it based on number of providers, it can also mean things for different places. I have seen patients in the ICU where the note says “medically stable.” That is medically stable for the ICU or whatever. We often in the post-acute arena get denied in different settings because they are medically stable. Why do they need to be there? That is in any of the four settings I have seen; there is a functional issue that goes along with that. So I would measure that. And, again, it doesn’t answer your question, but someone brought up “medical necessity,” which is a huge term.

Ms. JENKINS. Right.

Thank you, Mr. Chairman. I yield back.

Chairman TIBERI. Thank you.

Mr. Pascrell is recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

Dr. Gage, given your involvement, extensive as it is, and the development and analysis of a number of different value-based payment models, one of the things we are looking at very carefully, how do we best find what you and I could consider the appropriate balance of the number of measures to ensure that they are truly reflective of quality and patient experience but also not overly burdensome? How do we get to that point, or do we?

Ms. GAGE. I think we can. And I think the fields, the science of quality measurement, have evolved to the point where, instead of developing measures that could be used to make sure someone was receiving adequate care, which is how a lot of the quality measurement programs grew up, we can be looking at those factors that we start with, the never events. And the hospital QRP incor-

porated some of those. But there are also other events that are preventable: Decline in medical issues like the growth in pressure ulcers—

Mr. PASCRELL. I am sorry? I didn't hear that. A what?

Ms. GAGE. I am sorry?

Mr. PASCRELL. I didn't hear the last phrase you used.

Ms. GAGE. Oh. A decline in medical conditions, such as growth in pressure ulcers, that could have been avoided.

Mr. PASCRELL. Right.

Ms. GAGE. In the area of function, the expected improvement or, for a frailer population, the maintenance of one's mobility and self-care. So thinking about those key metrics that a patient is really going into the hospital to have cured, have treated, is one way of reducing—we see all sorts of measures in the ACO program and all sorts of measure options in the PQRS, et cetera, but we really need to start a discussion about which ones are really the sentinel medical outcomes, the sentinel functional outcomes and the cognitive factors.

Mr. PASCRELL. All right. Okay.

There's been some disagreement, as you know, as we all know, between Democrats and Republicans on the issue. It is likely there will be more in the future. I believe that the shift we have seen in our healthcare system away from fee-for-service toward a value-based system, quality-driven healthcare system, is a truly bipartisan idea—not a Democratic idea—a bipartisan idea. So the Affordable Care Act laid the foundation for building a healthcare system that rewards quality. We have a long way to go to that end. There are no two ways about it. It rewards quality. It rewards the outcomes and smart spending rather than the volume of services provided. This is what we started out to do, and we have a long way to go. There are no two ways about it.

So the Center for Medicare and Medicaid Innovation—we were talking about this this morning, ironically, in the Budget Committee—is testing a number of payment models that improve quality and lower the cost for the patient in the system.

Medicare has made, I think, great strides in rewarding quality. And earlier this year, HHS met the goal of tying 50 percent of Medicare payments to value by 2018. So we are moving in the right direction if the system is whole.

HHS is working toward the more ambitious goals of tying 85 percent—85 percent—of fee-for-service payments to the quality by the end of 2016. That is us, right? And 90 percent by the end of 2018.

This shift represents, I think, a fundamental change to the way our healthcare system operates now. So it is to be expected that there will be some growing pains and that some of the models we test will not turn out the way we hope. And maybe give us some examples, anybody.

What we started out to do, it didn't wind up so pretty at the end. But this is what we went through with Social Security. This is what we went through with Medicare. This is what we went through in Medicaid. And when you have both sides working together, it would seem to me, Dr. Gage, that we would have a better shot of making some changes that we all could live with, Mr. Chairman.

So what do you think, Dr. Gage? That is a toughie, but let's try it anyway.

Ms. GAGE. I think that is out of my expertise, and you showed with the IMPACT Act, the important work that can be done in pulling together a bipartisan bill, so I am sure that you have the wherewithal to do so.

Chairman TIBERI. Thank you. The gentleman's time has expired.

You are challenging me today, you and Mr. McDermott, really engaged in the Affordable Care Act. But I have been nice, very nice.

Mr. PASCRELL. It is our human way.

Chairman TIBERI. Mr. Paulsen, you are recognized for 5 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman.

I thank all of you for being here today.

Ms. Wynn, I just want to follow up on some of your testimony that you just had regarding the pros and cons of the current pay-for-performance programs for hospitals. I recently held a roundtable as well of hospitals in Minnesota. And like you, they have some of the same concerns about the duplicative and burdensome design of the programs. And one concern that they raised is the readmissions in hospital-acquired conditions programs are solely focused on payment penalties, and they don't give hospitals the opportunity to improve.

So is this a concern to hospitals in New York as well, and do you think hospitals should have the opportunity for a payment bonus that could be provided for good performance, for instance, in avoiding complications and readmissions?

Ms. WYNN. Yes. Thank you for that question. This is an issue that is foremost on the minds of our members as well. And maybe, if it is helpful, you know, one thing to think about is the way the penalty programs work for both readmissions and the complications is that there is no credit that is given to the industry if they do improve. And so, in order for a hospital to work its way out of the bottom quartile or the penalty phase within the HAC program, for example, they would have to improve—not only just improve, but improve faster than every other hospital across the country, right, because the bottom quartile is always penalized.

Mr. PAULSEN. Right.

Ms. WYNN. So I think the fear on the provider side is often that these programs are really just ways of, you know, cloaking payment cuts as opposed to really incentivizing high-quality care.

Mr. PAULSEN. Okay. And I have also heard from hospitals back home that the readmissions in hospital-acquired conditions programs make significant payment adjustments based on a very narrow number of conditions. So, therefore, small changes in performance in these limited categories have a disproportionate negative impact on payment.

Is this, again, a concern for hospitals in New York too? And should the payment impact on a hospital with higher rates of complications be required to be proportional to the actual financial impact of the complications?

Ms. WYNN. Yes. So, within the readmissions program, one of the major issues or design flaws that we see with the program today is that the savings to the Medicare program from the readmissions themselves is a fraction of the penalty that is being imposed on the hospitals through the penalties.

So, for example, on hip and knee replacement readmissions, the penalties that are being placed on hospitals are 20 times the size of the payments that the Medicare program is making to the hospitals for those actual readmissions. It feels like a very punitive penalty.

Mr. PAULSEN. Right. And for those same number of limited complications and readmissions, I mean, they don't reflect the vast types of patients' conditions that your hospital treats, which you alluded to before. In your opinion, does this limited approach also restrict a true evaluation of what a hospital's performance is, then, essentially?

Ms. WYNN. Yes. And one of the issues, and I appreciate you raising it, especially within the hospital-acquired conditions world is that these are rare events, and we would expect them to be rare events, but they can also randomly occur, essentially. And so when you are trying to get a precise measure of random variation, you can end up conferring very significant payment penalties for providers who really don't have a statistically significant difference in the quality of care provided at hospital A versus hospital B.

Mr. PAULSEN. Is there a program in New York that uses a more comprehensive definition of those types of complications and readmissions for payment adjustments?

Ms. WYNN. There is not, actually.

Mr. PAULSEN. Okay.

Ms. WYNN. In New York State, there had been a program through the Medicaid program, but that was eliminated 2 years ago.

Mr. PAULSEN. Okay.

Well, Mr. Chairman, just to follow up, it seems like the work that is going on in New York or in Minnesota, from what I am hearing from my hospitals, shows that there are providers and health plans in States out there that are trying to find ways to make the healthcare system more efficient and effective certainly and not trying to tie the healthcare system up in knots, but they are focusing on the outcomes that are high impact, that there are clinically credible outcomes that we can focus providers around to, essentially to achieve very substantial and sustainable improvements for patients.

I know that Representative Marchant is not here. I think we can learn a lot from these local initiatives. And we are going to be introducing legislation that will streamline the readmissions in hospital-acquired conditions programs into one easier to manage program so it will include providing both penalties and bonuses, computing penalties and bonuses that are proportional to the financial impact of the readmissions and complications, and then focusing on readmissions and complications that are actually avoidable, rather than just punishing our hospitals for things that are essentially outside of their control, and doing that in a budget-

neutral manner at the same time containing a very clinical and credible method of risk adjustment.

So I disagree with some of your comments. And maybe we can continue to follow up on that and proceed from there.

Ms. WYNN. We would be very interested in speaking with you about that.

Mr. PAULSEN. Thank you, Mr. Chairman.

I look forward to working with you on that as well.

Chairman TIBERI. Thank you, Mr. Paulsen.

I would like to recognize a leader in the value-based purchasing area. And, by the way, congratulations on those Badgers beating the SEC on Saturday. Just saying, Mr. Kind.

Mr. KIND. We will take it, especially early in the season. So thank you, Mr. Chairman, for that recognition.

First of all, I want to commend the panel today. I think your testimony has been very helpful and very good.

Mr. Chairman, thanks for teeing up this hearing.

I think this is the critical budgetary issue that is really facing this Congress and future Congresses for a long time. It is health-care reform. It is healthcare cost, which is really driving a lot of the budget decisions around here: The fact that 70 million Americans, the baby boomers, are now retiring and entering Medicare and the challenges that we are facing and how we best address that.

And I think there is consensus, as you probably heard on the dais here today, that there is a lot of alignment of interests of how we can align the healthcare delivery system so we get better outcomes at a better price. It is as simply put as that. And you guys are operating in this field right now. We are going to have to rely on your feedback and testimony like today in order to steer us in the right direction. And it is going to be a challenge.

And that is why I was happy, as Chairman Brady pointed out, to introduce with him, and working with Chairman Tiberi as well, the Post-Acute Care Value-Based Purchasing Act, because, as you mentioned in your testimony, Ms. Gage, when 40 percent of Medicare and hospital-based patients are going to enter the post-acute care setting, this is a huge area that also is going to require our attention on how we can incent the development of quality measures and then align the payment incentives the right way so we are getting better outcomes in the post-acute care center for our patients that is also fair to the providers.

Mr. Guenthner, I don't know if you or Almost Family have had an opportunity to take a look at the legislation we have introduced yet, but if you have, do you have any recommendations right now, any glaring things that stand out for you right now that you would bring to the Committee's attention on what we ought to be more focused on or try to avoid some unintended consequences of what we are trying to accomplish?

Mr. GUENTHNER. Well, thank you for the question. I think that we would suggest that the Committee take a hard look at the ACO experiences. The ACO model, it may well be the ultimate value-based purchasing model. This model connects physicians—it hits a lot of the goals that we talked about in our testimony. It connects the physician, fully informed with a full set of claims data, to the

patient, and thinking about that patient broadly, outside the walls of the office, outside the 15-minute office visit, outside the writing of the prescription, but thinking about that patient much more broadly. We do like the idea of providers, whether they are acute-care hospitals or home care agencies or anywhere in between, having a responsibility to a degree, to the degree that it is controllable, for what happens to that patient once they are discharged.

And we believe that our experiences in the ACO world, where our successful ACOs have increased their use of home health—they have increased their use of hospice. They have driven down the total spend by using these kinds of care. And they have significantly increased the number of primary care interventions that are happening at that patient level. And so we would encourage the Committee and staff to really take a hard look at those opportunities.

Mr. KIND. I couldn't agree with you more. I obviously hail from an area of the country, western Wisconsin, where I have gone to school on our providers there, whether it is the Mayo, or the Gundersen models, or Marshfield, or the ThedaCare, that have been really establishing models of care so that it is more integrated and more coordinated, the patient center that you have been advocating as well. And we have been looking at some very good outcomes.

But in the post-acute care world now, you have different providers with different charges. How do we get all of them on the same page so that they are more accepting of a more integrated patient-centered delivery model that others have shown?

Mr. GUENTHNER. Well, this is one of the reasons that, as you know, we are in favor of the Committee's work here and the need for the program to say to provider types, "This is what we want you to do," and then for providers to be held accountable to do those things.

And so, while there are imperfections in almost anything that we do, the need to move forward so outweighs the need to hold still, the need to do nothing. And so we have to continue to move forward to make progress, to try some new things, see if they work. And if they don't work, then we need to fix them. But we absolutely have to move forward.

Mr. KIND. I think moving forward with clear guidelines on what quality measures are the goal here, is going to be important too. I know there's been some kind things said about the IMPACT Act and the establishment of quality measures, of data collection. I know some of that is years down the road, which, being the impatient guy that I am, frustrates me that we have to wait a few years before a lot of this starts coming in, but making sure that the quality measurements are clear, that the goals are clear, and then we start aligning the financial incentives in order to encourage providers to hit that is going to be one of the goals we have with the legislation that we have introduced that hopefully we can achieve again with all of your help. So thank you, again, for your testimony here today.

I yield back, Mr. Chairman.

Chairman TIBERI. Mrs. Black is recognized for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman.

And I want to follow up on Mr. Kind's questioning.

I am hearing from some of the providers in my district that have concerns about the timing, the timing of when the IMPACT Act measures are coming online and when those measures can be ready for use in pay-for-performance programs.

My understanding is that some of the IMPACT measures are ready now, such as the Medicare spending per beneficiary measure, but some of the IMPACT measures are not yet finalized, such as the functional status. My question is, do we need to wait until all of the measures are ready to begin the pay-for-performance program, or do you think that we can start a program with the measures that are ready now and then transition other measures in a later timeframe? I wanted to ensure that any future developments in this space work hand in hand with the objectives that can be achieved with the IMPACT Act.

So, Ms. Gage, if I could start with you and have you give me your thoughts on that.

Ms. GAGE. Certainly. And just to broaden your thinking a little bit, in terms of timelines and readiness, the function measures have actually been endorsed by the National Quality Forum, and the standardized elements have been added to all of the assessments. And so those are actually quite ready.

And function is one of the greatest predictors of rehospitalization and other complicating factors. So it is a very important metric. Similarly, the medical complexity is another important factor, and much of that is standardized. Some of the work on cognition, which is an important risk adjuster for some smaller portion of the population, is still being finalized, although there are some available elements. And the work that the MedPAC did this past year, based on my team's former work with the post-acute care payment reform demonstration, showed that the items that are important in terms of predicting resource intensity or predicting readmissions or predicting functional change are among those that have been tested, are reliable, and are being considered in the different assessment tools.

So I think you are ready to move forward. You don't have as much specificity in your model, perhaps, as once the rest of the measures are also ready, but you have some key critical factors. And when you put transition times around payment model implementations, it softens some of those first-end complications.

Mrs. BLACK. Ms. Wynn, do you have a thought on that?

Ms. WYNN. I am not as familiar with the measures or the status of the measures in the post-acute world.

Mrs. BLACK. Mr. Guenthner.

Mr. GUENTHNER. Yes. Thank you.

We think the functional measures are incredibly important to patients. And I am thrilled to hear Dr. Gage tell us that those are ready. I think that, as I said in response to Mr. Kind's question, if the choice is to hold still or move forward, we are a big fan of moving forward. Now, one of the ways to mitigate some of the exposure around potential missteps is to moderate the amount of financial risk for providers so that we don't—if we miss, we don't—excuse me—overstate a miss by having too much at risk.

Mrs. BLACK. Doctor.

Dr. WORSOWICZ. I would agree with my colleague. If we are going to move forward, we need to make sure that we have some flexibility on the risk models. And with all these programs, it is an evolution that we are going to evolve in time, move things forward, have flexibility within the program.

Mrs. BLACK. Thank you.

I yield back.

Chairman TIBERI. Thank you.

Mr. Lewis is recognized.

Mr. LEWIS. Thank you very much, Mr. Chairman, and thank you for holding this hearing today.

And I want to thank every member of the panel for being here, for your great and good testimony.

Ms. Wynn, in your testimony, you explain how some types of hospitals are doing better in performance-based programs. You stated that hospitals servicing low-income patients and those that focus on teaching do not do as well. Can you explain more about the trend that you are seeing, the weaknesses?

Ms. WYNN. Sure. I would point back to the conversation around the readmissions penalty program and our concerns there that the rates of readmission are not risk-adjusted for the patient's socioeconomic condition. So, in terms of safety net hospitals, that definitely confers or imposes additional penalties on them relative to other hospitals.

And then, for teaching hospitals, they also tend to treat large socioeconomically disadvantaged populations, so they have the same issues on the readmissions side, but they are also disproportionately hit by the hospital-acquired conditions or complications penalty. Because these are rare events, what CMS does is they essentially put smaller hospitals that have very few of these events, they put them at the national average. And they say: These events are too rare for us to really calculate what your penalty should be, so we are going to assign you the national average.

In the complications penalty, it is only the bottom quartile of hospitals, so the bottom 25 percent, that is penalized, so that means that smaller hospitals that are assigned the national average will essentially never be penalized, right, because they can't work their way into the bottom quartile, and that leads to really the larger teaching hospitals and urban hospitals in the penalty bucket.

Mr. LEWIS. Thank you very much for your response.

Thank you. I yield back.

Chairman TIBERI. Dr. Price is recognized for 5 minutes.

Mr. PRICE. Thanks so much, and I appreciate the Chair's forbearance on schedule.

And I want to thank everybody for their testimony.

I want to highlight a couple of items. I was here earlier, as all of you were providing your testimony, and I was struck by, Dr. Worsowicz, your apt description that patients are unique and that one—it may have been you, Mr. Guenther—one patient with a diagnosis of a stroke is not like another patient with a diagnosis of a stroke. Same diagnosis, different treatment in that the quality decisions that are made ought to be made by patients and families

and doctors who are providing the care as opposed to somewhere else.

Mr. Guenthner, I want to talk about hopefully three specific, very clear items under the home health arena. First, is the reclaim review that has been proposed. On May 25th of this year, 116 bipartisan Members of the House sent a letter to CMS urging that CMS rescind the proposal for the five-State demonstration project. At one point, a Medicare official recommended that home health agencies fax in documents, as the electronic system was not working. Home health providers are experiencing submission issues that require more than 45 minutes for each and every preclaim review request. Preclaims rejection rate is between 70 and 80 percent. So physicians and others have complained to home health agencies and CMS regarding the intensive paperwork burden and confusion—on and on and on.

The question is, would we be aided by a delay in this demonstration so that CMS can get their act together, and we can help assist them to refine this program?

Mr. GUENTHNER. Yes, sir, I believe we would. As I commented in my testimony, this PCR, or preclaim review, topic is a direct result of the physician face-to-face requirement that included a subjective narrative that the home care industry, Almost Family included, commented to CMS was likely to result in very high audit error rates, because the auditor, 18 months or 2 years after the fact, would subjectively review the narrative written by the physician solely on the basis of the face-to-face document, not on the basis of the entire medical record.

Mr. PRICE. What could we do to remedy the face-to-face regulation?

Mr. GUENTHNER. I think that CMS has rolled some of this back. CMS has changed some of the requirements. We would like to see it much more prescriptive. We would like to see it much easier for physicians to execute. And what we have here is a trust problem. When the physician certifies the need for home care, they have certified that they have seen the patient, the only reason to have them have to write a narrative that could be challenged later is because we don't trust the physician's certification.

Mr. PRICE. Just checking the box?

Mr. GUENTHNER. Yes, sir.

Mr. PRICE. I want to jump to the Medicare appeals backlog in home health providers. In Georgia, there is a home health provider with \$92,000 denial on over 29 claims, in five locations. These claims have slowed to a crawl. Many of them have been going on for 4, 5 years in spite of a 90-day requirement under the statute. So it seems that this backlog is only growing, and I wonder if you would agree with me that a global appeal settlement similar to the ones used for hospitals would provide some relief to the ALJ hearing backlog?

Mr. GUENTHNER. Yes, sir, emphatically so.

Mr. PRICE. Thank you.

And I just want to highlight one other item, and that is the value-based purchasing model and the withhold that was set up for hospitals. And the percent withhold for hospitals was 1 percent, growing to 2 percent over a 5- to 6-year period of time, as I recall.

The proposal in the post-acute care space, as you know, is a 3-percent to an 8-percent withhold. When I speak to the folks trying to help patients back home and providing the care in the home health arena, they tell me that in many cases their margin isn't 8 percent. And so I wonder if it would—do you believe that it would be more appropriate, if they are going to go down this road, to have a withhold that is equivalent or the same as what the hospital community went through?

Mr. GUENTHNER. Yes, sir. We do think that parity is important across provider groupings and that the amount at risk should not get out in front of the infrastructure and the information available necessary for providers to execute.

If we get too much at risk, we have too high a risk of an adverse outcome or unanticipated event.

Mr. PRICE. Dr. Worsowicz, would you agree with that?

Dr. WORSOWICZ. Yes. I agree whatever you put at risk, we have to make sure we don't have an adverse outcome providing access to the patient.

Mr. PRICE. Thank you.

Chairman TIBERI. The gentleman's time has expired.

Mr. Crowley is recognized.

Mr. CROWLEY. I appreciate the Chairman. Thank you very much for giving me the opportunity to be a part of the panel today. I want to make sure you make the vote, as well as Dr. Price, and that I make it as well.

I did want to stay particularly to congratulate you for the bipartisan approach in terms of the panel today and the discussion that has gone on here as well. I think it is unusually a rational and coherent hearing today.

Particularly, I want to welcome Ms. Wynn to the panel. As a New Yorker, how incredibly proud I am of the work of New York hospitals working under tremendously difficult situations at times, given the complex challenges, complexity of the cases that New York sees and treating a very challenging population in many respects but at the same time still training one out of every six doctors in the United States. I think it needs to be said and applauded as well.

I think you made reference to particular challenges that teaching hospitals have in this environs and especially those in low-income and safety net communities. I think the word we are looking for is flexibility, having that flexibility of recognizing those challenges and not penalizing for those challenges, but recognizing and understanding them and meeting those needs so that the needs of the patients are met, certainly the quality. We all want the best outcome. The problem is, though, when patients come to the hospital not in stage I or stage II, but stage III and IV, because they don't have insurance and can't have insurance, it cost more to treat, and the outcome will just not be as good as patients who get there at stage I and stage II, where it costs less to treat and the outcome tends to be better. So I think that is an important point to recognize from the mere perspective, I think, for large cities as well.

I don't have any particular—I have some questions. We will get them to the Committee, maybe have all of you answer them.

I just want to thank the Chairman for this time.

Chairman TIBERI. Thank you, Mr. Crowley.

We have 2 minutes left to vote, so, unfortunately, we have to go.

I would like to thank the witnesses. You guys were awesome. I very much appreciate it. These are very important issues and I look forward to engaging with you in the future.

Please be advised that Members will have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the public record. Thank you.

With that, we are adjourned.

Ms. WYNN. Thank you.

[Whereupon, at 1:30 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]



September 21, 2016

via electronic submission: waysandmeans.submissions@mail.house.gov

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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 Guenther 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.

1 | Almost Family Feedback on Chair's amendment in the nature of a substitute to H.R. 3298, *Medicare PAC-VBP Act of 2015*

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>.

2 | Almost Family Feedback on Chair's amendment in the nature of a substitute to H.R. 3298, *Medicare PAC-VBP Act of 2015*

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.



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. They 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

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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
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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 to 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.



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**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 disproportionately 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.



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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
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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.

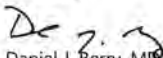
AJRR is the only national hip and knee arthroplasty Registry collecting data in all 50 states, and is the largest orthopaedic Registry with over 500,000 procedures, 810 hospitals, and 5,500 surgeons. AJRR collects Level I (patient, hospital, surgeon, and procedure info), some Level II (patient risk factors, 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



**American
Medical
Rehabilitation
Providers
Association**

Bruce M. Garis, 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
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The Honorable Sander M. Levin, Ranking
Member
Committee on Ways and Means
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1139E Longworth House Office Building
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The Honorable Pat Tiberi, Chairman
Committee on Ways and Means,
Subcommittee on Health
1104 Longworth House Office Building
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The Honorable Jim McDermott, Ranking
Member
Committee on Ways and Means
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U.S. House of Representatives
1139E Longworth House Office Building
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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).

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 Aup 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 withhold 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.

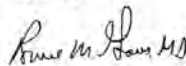
Again, we propose that the PAC VBP program be required to reinvest any withheld payments back into Medicare payments directly, which is the only sound way to ensure the program is budget neutral and does not cost-shift from one post-acute care sector to another. Separately, we urge the Committee to continue 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



*Occupational Therapy:
Living Life To Its Fullest®*

September 21, 2016

SENT BY ELECTRONIC MAIL

The Honorable Kevin Brady
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The Honorable Sander M. Levin
Ranking Member
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The Honorable Pat Tiberi
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The Honorable Jim McDermott
Ranking Member
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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.



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H.R. 3298: Medicare Post-Acute Care Value-Based Purchasing Act of 2015
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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 rates¹. 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

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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
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The Honorable Ron Kind
U.S. House of Representatives
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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.

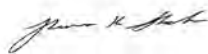
As a result, many Medicare beneficiaries have lost access to recreational therapy services, as some rehabilitation hospitals and units eliminated their capacity to provide recreational therapy services, and are no longer capable of offering these services to patients who need them. This hampers rehabilitation 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



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THE VOICE OF BRAIN INJURY

September 20, 2016

SENT BY ELECTRONIC MAIL

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The Honorable Sander M. Levin
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The Honorable Pat Tiberi
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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 Sylvia 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 of 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.

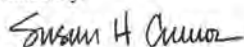
Therefore, the addition of one functional measure, while clearly imperative to both incentivizing quality improvement and permitting CMS to understand what it is getting in return for its payments to providers, is wholly inadequate to measure quality and outcomes of a wide variety of Medicare beneficiaries 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



September 21, 2016

SENT BY ELECTRONIC MAIL

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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 patient¹ 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 Sylvia 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/medicare-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

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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.

¹²Rachel 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

¹³U.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/650/672897.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.¹ 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.

¹ Institute of Medicine. "The Study of Geographic Variation in Healthcare Spending and Promotion of High Value Care." (July 2013). http://www.nationalacademies.org/handbook/media/Files/Report%20Files/2013/Geographic-Variation2/geovariation_1b.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 starting 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 than only functional status. In addition, Gundersen recommends the bill direct Health and Human Services to use the PAC QRP as a 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

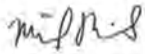
On behalf of Gundersen Health System, we greatly appreciate your continued support of advancing innovative, value-based payment programs and support for high quality care. We are supportive of

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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 HACs³ from 2010-2013, as designed, the HAC Reduction program will penalize 25% of hospitals every year,

¹ Salvijs Rice, "Most hospitals face 30-day readmissions penalty in fiscal 2016," *Modern Healthcare*, August 3, 2015, <http://www.modernhealthcare.com/article/20150803/NEWS/150803081>

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-quintile-of-hospitals-fail-again-to-escape-medicare-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. 16-0066-EF (Rockville, MD, 2015), <http://www.ahrq.gov/sites/default/files/specialty2/professionals/quality-patient-safety/pdfs/hacrate2013.pdf>

Mission: "The HQC strives to transition healthcare delivery and payment from wasteful, volume-driven incentives to a value-based (higher quality, lower cost) system. The HQC advocates advancing healthcare payment policies that encourage high value care and appropriately compensate for outcomes through measurable quality and cost criteria."

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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

Mission: "The HQC strives to transition healthcare delivery and payment from *volume*, *volume-driven* incentives to a *value-based* (higher quality, lower cost) system. The HQC advocates advancing healthcare payment policies that encourage high value care and appropriately compensate for outcomes through measurable quality and cost criteria."

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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/680/672892.pdf>

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

Mission: "The HQC strives to transition healthcare delivery and payment from *volume-driven incentives* to a *value-based* (higher quality, lower cost) system. The HQC advocates advancing healthcare payment policies that encourage high value care and appropriately compensate for outcomes through measurable quality and cost criteria."

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- 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



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 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 to 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.

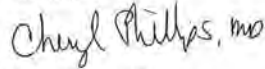
The LeadingAge Public Policy Congress has outlined principles for implementation of value-based purchasing, which we hope will be helpful to your committee:

- 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 nationwide: 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

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.

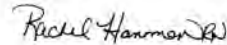
Although we appreciate the change reducing the withhold to 5%, this remains too substantial and significantly more than any other VBP program. We continue to believe this would particularly endanger smaller agencies in the rural parts of Texas that are already operating on slim margins. These smaller 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