September 21, 2016

SENT BY ELECTRONIC MAIL

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

The Honorable Sander M. Levin
Ranking Member
House Committee on Ways and Means
1236 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

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 patient[1] 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

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[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 Silvia 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.

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[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/medicares-value-based-purchasing-program-for-hospitals-paying-more-to-low-cost-hospitals-that-provide-low-quality-care/.

Sincerely,

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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 Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Association of University Centers on Disabilities
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

CC: House Ways and Means Committee Health LAs