A value incentive program for post-acute care providers

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September 6, 2019

A value incentive program (VIP) for post-acute care (PAC) builds on previous Commission work

- Recommended a uniform VIP for all PAC providers when a PAC PPS is implemented (2016). Began to develop a common set of measures.
- Defined a set of principles to tie quality to payments (2018).
- Recommended a re-designed hospital value incentive program that applied these principles (2018).
- Plan to apply these principles and design features to a value incentive program for post-acute care providers.

Rationale for a uniform value incentive program for post-acute care

- Medicare needs to tie its payments to quality of care to incentivize improvement.
- A unified prospective payment system across the four PAC settings will require a uniform VIP.
- Many beneficiaries treated in different PAC settings are similar. Providers should be evaluated using uniform measures.

Current SNF and HHA value-based payment programs do not meet Commission's principles

- Neither program has a small set of population-based outcome measures gauging quality, patient experience, and resource use
  - HHA: 20 measures, no resource use measure
  - SNF: 1 measure, no resource use or patient experience measure
- HHA program does not prospectively set performance targets
- Both programs' scoring includes incentive payment cliffs
- Neither program considers social risk factors in translating performance into payment
- There is no value-based payment for IRFs or LTCHs

PAC-VIP features: Proposed measures

- Small number of risk-adjusted, claims-based measures
  - All-condition hospitalization within the PAC stay
  - Successful discharge to the community
  - Medicare spending per beneficiary
- Data will be pooled over multiple years
  - Helps ensure measures are reliable for low-volume providers
  - Includes as many providers as possible in the program

PAC-VIP features: Scoring and rewarding/penalizing performance

- Performance will be scored using absolute, prospectively set targets.
- To account for social risk factors, providers with similar shares of dual-eligible beneficiaries will be compared in determining a provider's reward or penalty.
- A 5 percent withhold will fund the incentive payments.
  - Medicare margins are high for many PAC providers. A large withhold may be needed to influence behavior.

Proposed measure 1: All-condition hospitalization within the PAC stay

- Hospitalizations are a source of patient and family stress
- Uniform, claims-based, outcome measure
  - Holds PAC provider accountable for the care provided during the stay
- Mean rate = 17 percent (lower is better)
- Considerable variation across all providers
  - Ratio of 90th /10th percentile of providers = 3.1

Proposed measure 2: Successful discharge to the community

- Important goal of PAC is to safely return patients home
- Uniform, claims-based outcome measure
  - Holds provider accountable for outcomes after discharge
  - Successful discharge includes patients who have no hospitalizations and are still alive within 30 days of discharge
- Mean rate = 57 percent (higher is better)
- Considerable variation across all providers
  - Ratio of 90^{th} /10^{th} percentile of providers = 2.2

Proposed measure 3: Medicare-spending per beneficiary (MSPB)

- Incentivize providers to furnish efficient care
- Uniform, claims-based resource-use measure
  - Holds provider accountable for Parts A and B spending during the stay and for 30 days after
- Considerable variation across all providers
  - Ratio of 90th /10th percentile of providers = 1.7

Variation in performance across settings results in initial need to score within each setting

- Considerable variation in performance across PAC settings for each measure because:
  - Average lengths of stay vary by setting
  - Conditions of participation vary by setting
  - Shares of dual-eligible beneficiaries treated varies by setting
- To account for theses differences, PAC-VIP initially designed to be scored within settings
- As a unified PPS is implemented, could use same standards across all PAC providers

Score measure results using absolute performance targets for each setting

- Reward PAC providers based on clear and prospectively set performance targets
- Each measure has a continuous performance-to-points scale (from 0 to 10 points) for each setting
  - Our model will use a broad distribution of historical data to set the scale
- Each provider's PAC-VIP score is the average of the points across the three measures

Accounting for differences in social risk factors across providers through peer grouping

- Medicare should take into account, as necessary, differences in provider populations, including social risk factors
- Adjusting measure results for social risk factors can mask disparities in clinical performance
- Medicare should account for social risk factors by directly adjusting payment through peer grouping

Use setting-specific peer grouping to convert performance to rewards and penalties

- Define peer groups by share of patients eligible for full Medicaid benefits as a proxy for social risk
- Convert PAC-VIP points to payment adjustments within setting-specific peer groups
  - Each peer group has a pool of dollars that is redistributed based on PAC-VIP points
  - Each peer group has its own payment multiplier per PAC-VIP point, based on the group's pool of dollars and HVIP points

Next steps and discussion

- PAC-VIP is essential to incentivize provider improvement
- Plan to model the PAC-VIP based on the Commission's feedback and present our results in the spring
- Seek feedback on design of the PAC-VIP
  - Measure set
  - Scoring methodology
  - Size of the withhold