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# MEMORANDUM

**To: ACRM**

**From: Peter Thomas and Joe Nahra**

**Date: September 12, 2019**

**Re: Summary of MedPAC Meeting: A Value Incentive Program for Post-Acute Care Providers**

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On September 6, 2019, the Medicare Payment Advisory Commission (MedPAC), an independent legislative branch agency that provides Congress with analysis and policy advice on the Medicare program, held a meeting that included a session titled *A Value Incentive Program for Post-Acute Care Providers*. MedPAC staffers Ledia Tabor and Carol Carter presented on this topic using the associated slide deck, which can be found [here](http://www.medpac.gov/docs/default-source/default-document-library/pac-vip-sept-2019-final.pdf?sfvrsn=0).

The presentation provided an overview of a proposed design for a post-acute care value incentive program (PAC-VIP), building on MedPAC’s previous work to define principles to tie quality to payment for PAC. Staff outlined proposed measures, performance scoring, and risk adjustment/peer grouping. The presentation set the stage for a discussion of the proposed PAC-VIP design and areas to improve or examine further when developing the model. The Commissioners offered questions and feedback on the presentation and the future of PAC value-based payment.

**Overview of the Presentation**

MedPAC staff discussed the Commission’s previous work on value-based PAC payment, including the initial recommendation for a uniform VIP in 2016 and a set of principles to tie quality to payment in 2018. Staff contended that a unified PAC-VIP is necessary to incentivize improvement in quality of care and to continue to lay the groundwork for a unified PAC prospective payment system (PPS). Staff also provided a brief overview of the current value-based programs in place with the SNF and HHA payment systems, but cautioned that they do not meet the Commission’s 2018 principles in their current form. Specifically, staff highlighted the facts that neither program has a resource use measure, that both programs include incentive payment cliffs, and that neither considers social risk factors in translating performance into payment.

Staff provided an outline of the proposed PAC-VIP, which includes three risk-adjusted, claims-based measures:

1. All-condition hospitalization within the PAC stay
2. Successful discharge to the community, and,
3. Medicare spending per beneficiary or “MSPB.”

In order to ensure measure reliability for low-volume providers and to include as many providers as possible, the model would pool data over the past three years. Performance in the model would implement peer grouping based on providers’ share of dual-eligible beneficiaries. MedPAC staff initially proposed a 5 percent payment withholding to fund the incentive payments, but asked the Commissioners for feedback on the final number. The initial model does not include a patient experience measure, but staff asked for Commissioner feedback on including such a measure. Staff opted against including a provider-reported patient functional assessment measure due to concerns about inconsistent reporting outlined in the June 2019 MedPAC report. [The recommended omission of a functional measure or measures is very concerning and should be the subject of future comment to MedPAC on this issue.]

Initially, the model will assign scores within each of the four PAC settings separately, due to considerable variation in performance on the proposed measures across settings. Staff noted that as a unified PAC PPS is implemented, scores and target benchmarks could be unified across settings. The model would assess providers with a ten-point score for each of the three measures, and average the scores to create a total PAC-VIP score. These scores would then be converted to payment adjustments within setting-specific peer groups to redistribute the pool of dollars initially withheld from PAC payment. Staff specifically requested feedback from the Commissioners on the proposed set of measures, scoring methodology, and size of the payment withhold.

**Questions from the Commissioners**

Commissioner Jonathan Jaffery asked staff for specific areas to consider when discussing the size of the payment withhold, and questioned what evidence was available to support an effective withhold to drive provider behavior. Staff suggested a larger withhold in order to make an impact on providers, and suggested that they conduct comparative models for outcomes with high and low withholds. Commissioner Warner Thomas asked staff for clarification on the current withholds for value-based programs in place now, and staff responded that the HHA VIP withhold is currently 4%, and is scheduled to rise up to 8%, while the SNF VIP withholds 2% of payments.

Commissioner Thomas questioned whether those programs have had any impact on behavior or outcomes in the HHA and SNF areas. Staff responded that there has been some improvement in provider-reported outcomes and process measures for HHAs, but no change in claims-based measures. For SNFs, staff reported very little observable impact for the value-based payment program. Staff added that there has been some observation of cherry-picking in SNFs as a result of the VIP, but MedPAC has not conducted a specific analysis, and expects cherry-picking to diminish with the proposed PAC-VIP design.

Commissioner Dana Gelb Safran questioned how large of a sample size is needed in order to ensure stable and reliable data for each of the three measures. Staff responded that in order to account for small or low-volume PAC providers, the MedPAC model pools the past three years of data to achieve a reliability measure of 0.7. The model includes a minimum beneficiary sample of 60 patients in order to be included in the VIP, which MedPAC predicts will exclude 10% of SNFs, 20% of HHAs, and 2-4% of IRFs and LTCHs.

Commissioner Safran asked how the Medicare program can build better functional status measures to address the Commission’s concerns. Staff replied that they do not want to “give up” on functional status assessment, and pointed to the strategies outlined in the June 2019 report (including increased Medicare audits, point-of-discharge assessment, and patient-reported outcome measures) as ways to improve patient function measures.

Commissioner David Grabowski questioned the effectiveness of the proposed risk adjustment across settings, and asked whether the model would track measure performance for specific conditions within the different PAC settings. Staff responded that while CMS has used setting-specific models for risk adjustment, MedPAC strived to use a uniform measure design to support the long-term goal of unified PAC payment. Staff acknowledged that this represents a tradeoff between uniformity and accuracy. Commissioner Grabowski asked if staff could check the reliability of the model with setting-specific coefficients.

Commissioner Kathy Buto pointed out that under a unified PAC PPS, providers may become more specialized for beneficiaries with conditions they treat particularly well. She questioned whether the proposed unified risk adjustment would be able to handle specialization within the next phase of PAC evolution. Commissioner Brian DeBusk asked if the diagnosis and comorbidity adjusters currently reflected in the risk adjustment would absorb such provider specialization, and staff responded that they may not, because the risk adjustment coefficients reflect the full pool of patients in the entire VIP model, so they might not have sufficient weight to sway payment for specialized providers.

Commissioner DeBusk also noted that the nature of the three measures might allow for providers to “fail twice;” for example, if a patient is readmitted to PAC after discharge, the provider would receive a low score both for successful discharge to community and Medicare spending per beneficiary. Staff responded that such double-counting could occur, but would serve the larger goal of improving patient outcomes. Additionally, staff noted that the all-condition hospitalization measure only includes admissions within the PAC stay, so providers would not be penalized for post-discharge readmissions on that measure.

Commissioner Pat Wang noted that HHAs in particular may require setting-specific adjustments to reflect the unique nature of the home health patient population. She emphasized that the model should not obscure the most appropriate quality measures in the service of uniformity across PAC settings. Staff responded that for Medicare spending per beneficiary in particular, there will need to be an adjuster even with uniform measures to account for the fact that home health spending is only 1/6th of the spending on hospital stays.

Commissioner Susan Thompson asked whether the model accounted for different admission sources, and staff responded that it does not – there are no adjusters for admissions from the community versus from hospitals. Commissioner Buto asked whether the successful discharge to community measure would be more appropriate for HHAs than for some LTCHs and SNFs. Staff responded that in designing the measure, MedPAC counted discharges to nursing homes for beneficiaries who reside full-time in nursing homes as successful community discharges.

**Discussion**

Commissioner Safran stated that unified PAC payment will not be possible without some form of a PAC-VIP. She emphasized that in addition to the three proposed measures, PAC-VIP should include some form of a patient experience measure as well as a functional status measure, although she acknowledged the issues with provider-report function assessments. She expressed concern about comparing performance across PAC settings. Commissioner DeBusk asked whether MedPAC should explore additional measures for patient experience, and asked staff to revisit the proposed peer grouping methodology as changes to the PAC PPS drive unification. He supported a higher withhold for the PAC-VIP, suggesting up to 8% with a scheduled “ramping up.”

Commissioner Amol Navathe restated the importance of tracking provider specialization and whether such specialization could result in care that is unrecognizable by the PAC-VIP model. He also questioned whether MedPAC has two divergent goals (creating value-based payment for PACs, and assigning patients to the most appropriate PAC setting) that may in some cases oppose each other. He expressed concern about creating perverse incentives for providers after a fully unified PAC PPS is implemented.

Commissioner Lawrence Casalino discussed the claims-based measure, and questioned whether claims data can accurately distinguish between patients with significantly varying severity but the same diagnosis. He specifically noted stroke as a diagnosis that can result in temporary or permanent damage, and questioned whether the PAC-VIP model would be able to accurately compare the care provided to two different stroke patients. Additionally, he questioned whether unification across PAC settings is feasible, specifically because HHAs are not likely to be treating institutional patients.

Commissioner Navathe discussed the impact of the data pooling included in the proposed PAC-VIP model. He expressed concern that for high-volume providers who do in fact change their behavior as incentivized by the VIP, it may be difficult to overcome the backlog of less valuable treatment provided to patients in previous years, or to sway the overall scores in the VIP. Staff responded that they would explore whether to weight the most recent year more heavily in order to avoid this issue. Commissioner Safran also suggested that retroactive three-year pooling should only occur when necessary; e.g., when a provider exceeds the 60-beneficiary minimum threshold in a single year, the model should not review the prior year’s cases to measure performance.

Commissioner Wang questioned whether the share of dual-eligible beneficiaries was the most appropriate way to assess risk-adjustment for social determinants of health, and asked staff to explore more predictive measures. Commissioner DeBusk suggested that in early periods of the PAC-VIP, staff conduct periodic analyses of socioeconomic status and other demographic data for patient populations to measure whether the model’s risk adjustment is appropriate. Commissioner Safran suggested also tracking 9-digit ZIP codes during the initial periods of the PAC-VIP.

Commissioner Bruce Pyenson returned to the discussion of the size of the payment withhold, and suggested that the Commission should analyze not just the proportion that drives provider behavior, but the proportion that would create significant financial risk for providers. He also suggested creating a sliding scale withhold amount that would vary by provider size. Vice Chairman Paul Ginsburg added that higher withholds would increase the amount of capital required to enter the PAC market, and suggested that MedPAC conduct analyses of the impact of varying withhold amounts on small/large and for-profit/non-profit providers. Commissioner Jaffery questioned whether the Commission could develop a model that provided for real-time, rather than delayed payments, in order to reduce the burden of withholds across the board.

PAC VIP and overall PAC unified payment reform will continue to be a major issue that MedPAC addresses later this year culminating in separate reports to Congress in March 2010 and June 2020. We will continue to closely monitor this debate and report accordingly.