Mandated report: Skilled nursing facility value-based purchasing program

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Value-based purchasing (VBP) programs

- Creates incentives for providers to furnish efficient, high quality care
- Payments are tied to performance measures
- As required by the Protecting Access to Medicare Act 2014, CMS implemented a VBP for skilled nursing facilities (SNF) on October 1, 2018

Mandate to evaluate the SNF value-based purchasing program

- Evaluate the program
  - Review progress
  - Assess impacts of beneficiaries' socio-economic status on provider performance
  - Consider any unintended consequences
- Make recommendations as appropriate
- Report due June 30, 2021

Timetable for meeting report deadline

September 2020	October 2020	January 2021	March & April 2021
• Outline current design • Review results of Years 1 & 2 • Identify shortcomings of the design	• Outline an alternative design • Estimate potential impacts • Compare impacts of current and alternative designs	• Consider an alternative design for the VBP	• Review draft and final report • Report may include recommendations

Elements of a VBP design

Measures	**Minimum volume**
Used to gauge performance	Required to have performance evaluated
Scoring	**Financing**
To translate performance into a payment adjustment	To fund rewards or penalties

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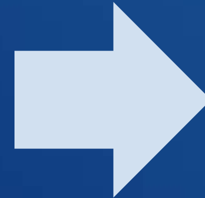
SNF VBP design: Performance measure is specified in statute

Current	Future
Risk-adjusted all-cause, unplanned readmissions Counts readmissions within 30 days of discharge from the hospital	Replace with risk-adjusted potentially preventable readmissions “as soon as practicable”



SNF VBP design: Scoring

- Score based on the higher of achievement or improvement (in statute)
- Targets are set prospectively
- Score is converted to a provider-specific adjustment applied to each payment
- Payments are lowered for providers with the lowest 40% of rankings (in statute)

SNF VBP design: Minimum volume and financing

Minimum volume

- 25 stays per year
- SNFs with fewer stays are held harmless by the program

Financing

- 2 percent withhold (in statute)
- Statute requires between 50% and 70% returned to providers—CMS opted for 60%
  - 40% of withheld amount is retained as program savings

Net impact of the SNF VBP on payments

Share of SNFs:	FY 2019	FY 2020
Payments were lowered	73%	77%
Earned essentially none of the amount withheld (2%)	21%	39%
Received the maximum increase	3%	2%
Maximum net payment after 2% withhold	1.6%	3.1%

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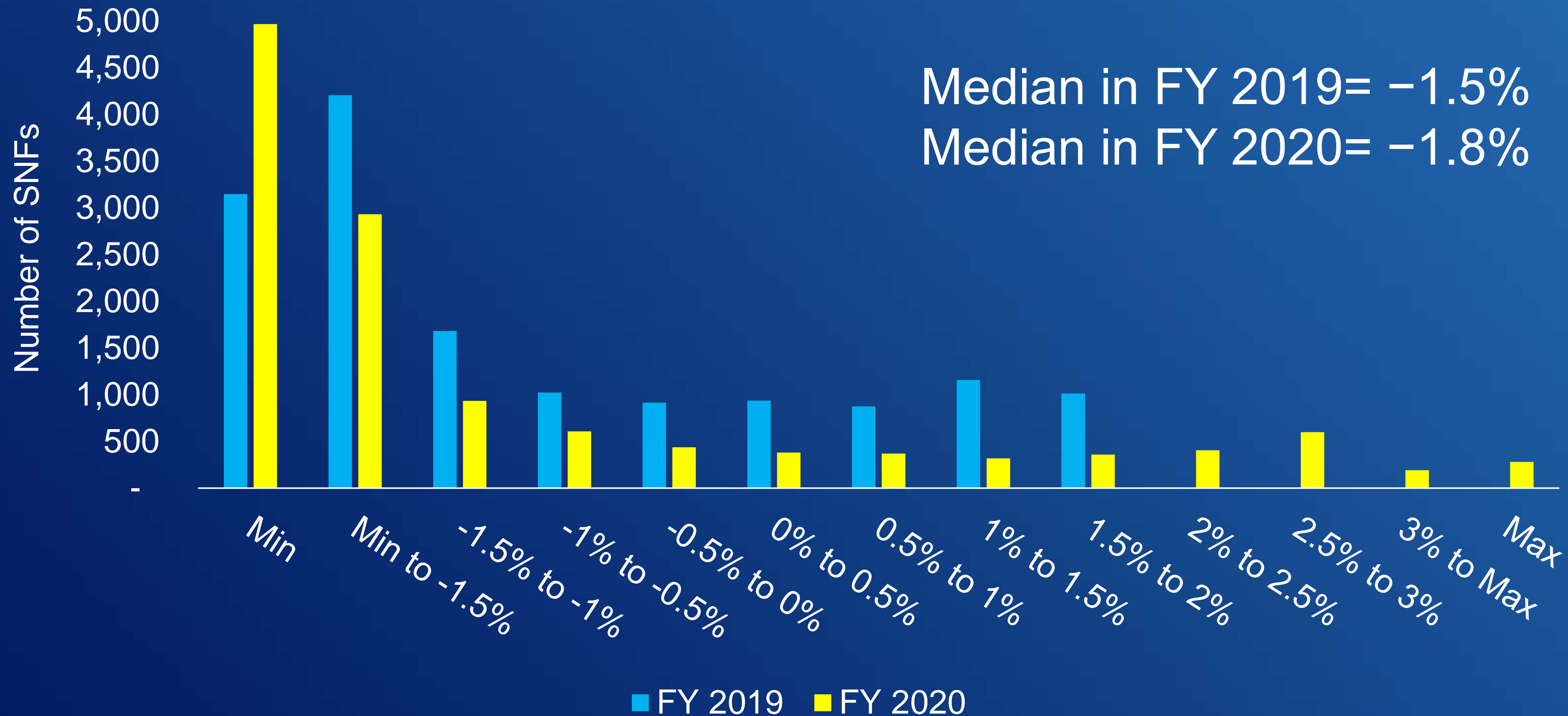
Data are preliminary and subject to change

Payment adjustments in FY 2020 varied more than adjustments made in FY 2019



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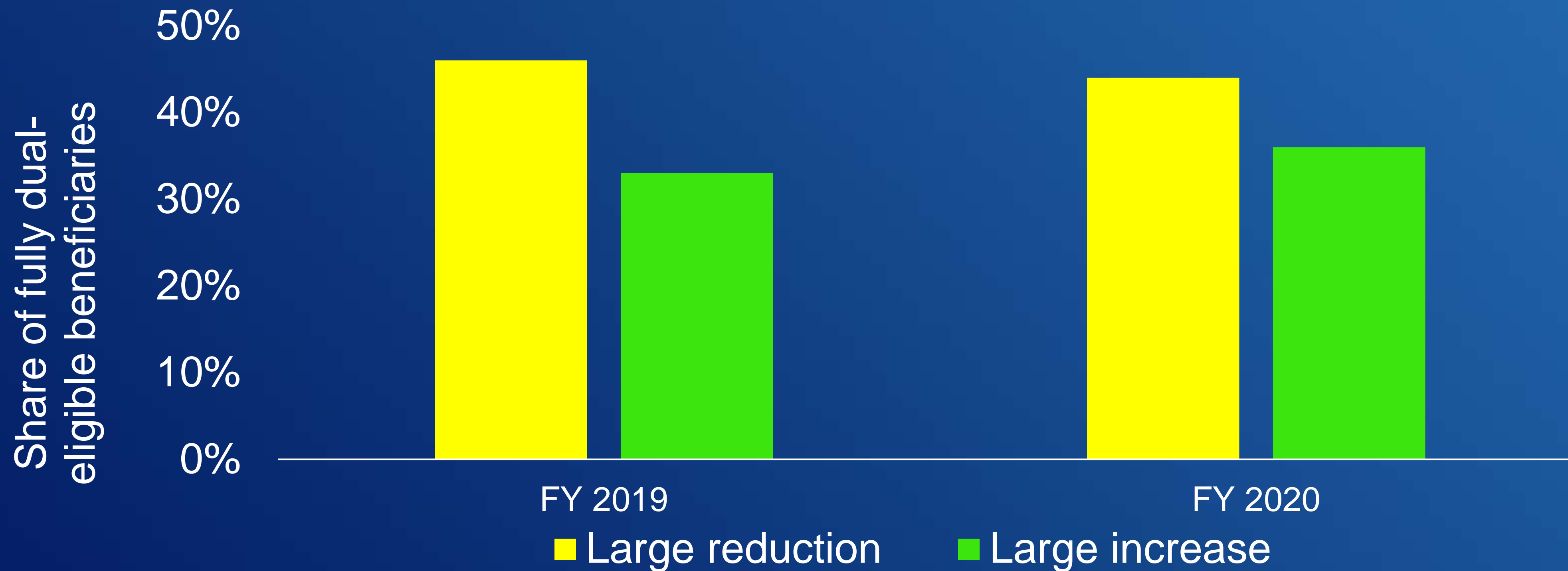
Except for the SNFs with the largest reductions, little consistency in adjustments between years

- Many SNFs received a large reduction to payments in FY 2019 and FY 2020. Except for those, there was little consistency in performance across years.
- Compared with 2019, more SNFs received a lower payment adjustment than received a higher payment adjustment in 2020
- The lack of consistency in performance across years could indicate that the minimum count is too low

Payment adjustments were associated with a provider's share of fully dual-eligible beneficiaries



Note: Large reduction defined as a payment reduction greater than 1.5%. Large increase defined as a payment increase greater than 1.5%

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Performance was related to provider characteristics

- Incentive payments increased
  - Higher volume
  - Higher occupancy
  - Hospital-based
- Incentive payments decreased
  - Higher patient risk scores
  - Higher shares of fully dual-eligible beneficiaries

MedPAC principles for quality measurement

Measures	Scoring	Account for social risk factors
• Small set of outcome, patient experience, and value or resource use measures • Not burdensome to report	• Use absolute, prospectively set standards • Use a continuous scale that avoids cliffs in penalties or rewards	• Take into account, as necessary, differences in providers' populations, including social risk factors through peer grouping

SNF VBP design does not meet these principles

Shortcomings of the SNF VBP design

Single performance measure

- Quality is multi-dimensional
- Quality should gauge outcomes, resource use, and patient experience

Minimum count is too low

- Minimum count does not meet a common standard of reliability
- Count needs to ensure that providers can be accurately differentiated

Shortcomings of the SNF VBP design, continued

Scoring does not encourage all providers to improve

- Statute requires the bottom 40% of providers to have their payments lowered
- Thresholds in scoring create cliffs

Quality payment does not account for social risk factors

- Providers may lack the resources needed to invest in quality improvement

Size of the amount withheld is too small

- Incentive payments are too small to motivate providers to improve

Next steps

- In October, present the outline of an alternative design that corrects the current shortcomings
  - Estimate potential impacts
  - Compare impacts of current and alternative design
- Discussion topics for today
  - Results of the program
  - Shortcomings of the VBP design

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