

# Mandated report: Designing a value incentive program for post-acute care

Carol Carter and Ledia Tabor  
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# Mandate to establish a prototype value-based purchasing program under a unified PAC PPS

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- Mandate in the Consolidated Appropriations Act, 2021
- Report shall:
  - Consider design elements
  - Analyze the effects of implementing program
  - Make recommendations as appropriate
- Report due March 15, 2022

Note: PAC (post-acute care). PPS (prospective payment system).

# Today's discussion

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- Five design elements of a PAC value incentive program (VIP)
  - Would apply to all PAC settings (SNFs, HHAs, IRFs, LTCHs)
  - Consistent with SNF VIP recommendation
- Results of illustrative modeling of PAC VIP design
- Feedback on findings

Note: SNF (skilled nursing facility). HHA (home health agency). IRF (inpatient rehabilitation facility). LTCH (long-term care hospital).  
The Commission recommended replacing the SNF VBP with the SNF VIP in the June 2021 report to the Congress.

# PAC VIP: Score a small set of performance measures

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## Design

- Performance gauged with a small set of measures
- Measures uniformly defined across settings
- Measure set should evolve over time (i.e., patient experience)

## Illustrative model

- Hospitalizations within stay, Medicare spending per beneficiary, and successful discharge to the community

# PAC VIP: Incorporate strategies to ensure reliable measure results

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## Design

- High reliability standard to determine minimum number of stays required for scoring

## Illustrative model

- Used reliability standard of 0.7
- Minimum of 60 stays for each measure
- Performance period spans 3 years to include as many providers as possible

# PAC VIP: Establish a system for distributing rewards with minimal “cliff” effects

## Design

- Design distributes rewards with minimal “cliff” effects
- All providers are encouraged to improve
- Comparisons within setting until unified PAC PPS is implemented

## Illustrative model

- Performance assessed against a national distribution within each setting
- Scales that convert performance to points ensure that every achievement is recognized

PAC VIP: Account for differences in patient's social risk factors using a peer grouping mechanism, if necessary

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## Design

- If providers with populations at high social risk are disadvantaged in achieving good performance, stratify providers into peer groups
- Payment adjustment based on performance relative to peers

## Illustrative model

- Uses peer groups to distribute payment incentives, if warranted
- Performance scores are not adjusted, while payments are adjusted

# PAC VIP: Distribute a provider-funded pool of dollars in its entirety

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## Design

- Distributes all withheld funds back to providers as rewards based on their performance

## Illustrative model

- Withheld 5%; all distributed back to providers
- Program is not used to achieve program savings



# Examined two measures to account for social risk

- To determine if peer grouping was needed in each setting, we assessed the relationship between performance and two measures of social risk using correlations

Share of fully dual-eligible beneficiaries treated	Average ADI of communities where patients live
Proxy for beneficiary income	Proxy for income and other social risks
Beneficiary-level measure	Measures characteristics of a community
Evidence tying the measure to health outcomes	
Calculated from administrative data	

Note: ADI (Area Deprivation Index). ADI ranks neighborhood disadvantages using 17 social risk factors from American Community Survey data collected by the U.S. Census. ADI developed by University of Wisconsin School of Medicine and Public Health.

Higher social risk was not consistently related to worse performance, so peer grouping may not always be needed

Measure of social risk	<u>Performance</u>	
	Better	Worse
High share of fully dual-eligible beneficiaries treated	LTCH HHA	<b><i>SNF</i></b> <b><i>IRF</i></b>
High average ADI of communities where patients live	LTCH IRF	<b><i>SNF</i></b> <b><i>HHA</i></b>

- Decisions on the need for peer grouping and measure of social risk could be made separately for each setting

Note: **Green** notes where the measure of social risk was associated with worse performance. Peer grouping may be warranted to account for differences in provider patient populations.  
Results are preliminary and subject to change.

# PAC VIP modeling results and implications for peer groups: SNFs

Results	Implications
<ul style="list-style-type: none"><li>• Using either measure of social risk, SNFs treating patient populations at high social risk had worse performance</li><li>• Compared with ADI, the share of dual-eligible beneficiaries had stronger relationship to performance, even after risk adjustment</li></ul>	<ul style="list-style-type: none"><li>• Peer grouping helps counter disadvantages some SNFs face when treating patients at high social risk</li><li>• Peer groups based on duals status may be better marker because it is specific to the beneficiaries treated by a SNF</li></ul>

Note: SNF (skilled nursing facility). ADI (Area Deprivation Index).  
Results are preliminary and subject to change.

# PAC VIP modeling results and implications for peer groups: IRFs

Results	Implications
<ul style="list-style-type: none"><li>• Varied by measure of social risk</li><li>• IRFs with high shares of fully dual-eligible beneficiaries had slightly <b>worse</b> performance</li><li>• IRFs with high ADIs had <b>better</b> performance</li></ul>	<ul style="list-style-type: none"><li>• Peer grouping based on duals' share modestly helps counter the disadvantages some IRFs face when treating patients at high social risk</li><li>• Duals status may be better marker of social risk because it is specific to the beneficiaries treated by an IRF</li></ul>

Note: IRF(inpatient rehabilitation facility), ADI (Area Deprivation Index).  
Results are preliminary and subject to change.

# PAC VIP modeling results and implications for peer groups: LTCHs

Results	Implications
<ul style="list-style-type: none"><li>Using either measure of social risk, LTCHs treating patient populations at high social risk had <b>better</b> performance</li></ul>	<ul style="list-style-type: none"><li>Peer grouping may not be needed</li></ul>

Note: LTCH (long term care hospital). ADI (Area Deprivation Index).  
Results are preliminary and subject to change.

# PAC VIP modeling results and implications for peer groups: HHAs

Results	Implications
<ul style="list-style-type: none"><li>• Varied by measure of social risk</li><li>• HHAs with high shares of dual-eligible beneficiaries had better performance</li><li>• HHAs with high ADIs had worse performance</li></ul>	<ul style="list-style-type: none"><li>• Peer grouping based on ADI would help counter disadvantages some HHAs face when treating patients at high social risk</li><li>• ADI captures the communities' risk factors that are relevant to the home-based care</li></ul>

Note: HHA (home health agencies), ADI (Area Deprivation Index).  
Results are preliminary and subject to change.

# Summary: PAC VIP could be implemented with a mix of common and setting-specific features

Common design elements	Setting-specific features
<ul style="list-style-type: none"><li>• Score a small set of performance measures</li><li>• Incorporate strategies to ensure reliable measure results</li><li>• Establish a system for distributing rewards with minimal “cliff” effects</li><li>• Distribute a provider-funded pool of dollars in its entirety</li></ul>	<ul style="list-style-type: none"><li>• Compare performances across providers <i>within</i> a setting, at least initially</li><li>• Account for differences in patient’s social risk factors using peer grouping, if needed</li></ul>

# Discussion

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- Results raise questions about peer grouping:
  - How do you approach peer grouping if the relationships between social risk measures and outcomes differ?
  - How do you determine which is the right measure of social risk to use?
- Feedback on:
  - Design elements
  - Interpretation of illustrative modeling results