HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #1

Expand the Successful Home Health Value-Based Purchasing Model to Providers that Report Similar Quality Measures

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Executive Summary

The Medicare Part A Trust Fund is projected to become insolvent by 2028. The successful Innovation Center demonstration—the Home Health Value-Based Purchasing (HHVBP) model—offers one option for partially addressing the Trust Fund's insolvency. The Centers for Medicare & Medicaid Services has made the model a permanent program for home health services. Congress could direct the agency to implement similar programs for other providers that already report similar quality measures—inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and hospice providers. In aggregate, such value-based purchasing programs could reduce Medicare Part A spending by more than $12 billion over 10 years, extending the life of the Trust Fund, and improve the quality of care for beneficiaries.

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Issue

The Medicare Trustees expect that Medicare's Part A Trust Fund will become insolvent by 2028, due to income from dedicated payroll taxes not keeping pace with expenditure growth.[1] Total Medicare expenditures are projected to nearly double over the next decade while the number of workers per Medicare beneficiary who pay HI Trust Fund taxes continues to decline. As a result, the difference between Part A expenditures and income is expected to exceed $390 billion over the next decade.[2]

One option for addressing this funding shortfall, in part, is suggested by the Home Health Value-Based Purchasing (HHVBP) model. This demonstration is one of only four models that have met statutory requirements that allow Centers for Medicare and Medicaid Services (CMS) Innovation Center models to be expanded or implemented nationwide into the Medicare program if they reduce program spending, improve the quality of care, or both.[3] It was introduced into the regular Medicare program as the Expanded HHVBP model, affecting home health providers in all states, beginning January 1, 2022.[4,5]

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[1] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[2] Ibid.
[3] Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation, Social Security Administration
[4] Expanded Home Health Value-Based Purchasing Model, CMS.
[5] Medicare and Medicaid programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement

The original HHVBP model offered financial incentives and risks to home health agencies (HHAs) in 9 states for quality improvement based on their performance relative to other agencies in their state.[6] Participating HHAs were rated using Total Performance Scores (TPS) that combined results for individual measures of quality of care.[7] A maximum payment adjustment to Medicare fee-for-service (FFS) payments was applied to each participating HHA, based on its TPS:

- ± 3% in 2018,
- ± 5% in 2019,
- ± 6% in 2020,
- ± 7% in 2021.

The most recent evaluation results indicate that the HHVBP model resulted in cumulative Medicare savings of $949.2 million as of 2020. These savings are a 1.6% reduction relative to non-participants.[8] The savings were the net result of:

- Decreases in spending:
  - $546.8 million (2.8%) reduction in inpatient hospitalization stay spending
  - $201.2 million (4.0%) reduction in skilled nursing facility services spending

- Increases in spending:
  - $87.5 million (6.4%) increase in emergency department and observation stay spending[9]

While results for specific quality measures were mixed over this time, the aggregated TPS results were consistently higher for participating HHAs than for non-participants.[10] In 2020, overall model participants' average scores were 7% better than the comparison group.[11] Beneficiaries aligned with the HHVBP model HHAs experienced improvements over time in functional status during home health episodes that exceeded those observed in non-HHVBP states.[12] The evaluation found no adverse effects on beneficiary use of home health services or access to home health care.[13]

Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID-19 Reporting Requirements for Long-Term Care Facilities Final rule. CMS-1747-F and CMS-5531-F (November 2021)

[6] Findings At a Glance: Home Health Value-Based Purchasing Model Evaluation of the First Five Performance Years (2016-2020), CMS (April 2022)

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] Alyssa Pozniak, Marc Turenne, Eric Lammers, et al. Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model: Fifth Annual Report. (April 2022)

[11] Ibid.

[12] Ibid.

[13] Findings At a Glance: Home Health Value-Based Purchasing Model Evaluation of the First Five Performance Years (2016-2020), CMS (April 2022)

The new Expanded HHVBP model began January 1, 2022, with a pre-implementation year that allows HHAs to gain experience with the new model before being assessed on their performance. The Expanded HHVBP model will first affect HHA's payments in 2025, based on agencies' performance in 2023.[14] Payment adjustments will range from -5% to +5%.[15] HHAs' performance will be assessed based on data from:

- **Outcome and Assessment Information Set (OASIS)**—which includes information submitted by HHAs on measures such as discharge to community and patient improvements.
- **Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)**—which includes information collected from surveys of HHA patients (or their family or friends) about their experiences with a HHA, and
- **claims-based measures**—of inpatient hospital and emergency department use.[16,17,18]

Proposed Policy

CMS's Innovation Center has yet to test models like HHVBP for similar providers, even though these providers are subject to a set of quality measures similar to those used for HHVBP. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the submission of standardized quality and resource use data by HHAs, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs).[19] In addition, the Patient Protection and Affordable Care Act (ACA) requires standardized quality reporting programs (QRPs) for various providers, including post-acute care and hospice providers.[20] Under QRPs, IRFs, LTCHs, SNFs, and hospice providers are subject to payment update penalties for failure to report quality measure data that range from 2% to 4%.[21,22,23,24]

Given the evidence generated by the Innovation Center's HHVBP model and the similarities with other post-acute care settings, Congress could enact legislation directing the Secretary of the Department of Health and Human Services to implement similar models in the traditional Medicare program for IRFs, LTCHs, SNFs, and hospice providers.

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[14] Medicare and Medicaid programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Model Expansion; Home Health and Other Quality Reporting Program Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; and COVID-19 Reporting Requirements for Long-Term Care Facilities Final rule. CMS-1747-F and CMS-5531-F (November 2021)
[15] Ibid.
[16] Ibid.
[17] Home Health Quality Measures, CMS.
[18] Home Health Value-Based Purchasing (HHVBP): HHVBP Model Expansion 101, CMS (February 2022)
[19] IMPACT Act of 2014 Data Standardization & Cross Setting Measures, CMS.
[20] Patient Protection and Affordable Care Act of 2010 (March 2010)
[21] Hospice Quality Reporting Program, CMS.
[22] Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), CMS.
[23] Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), CMS.
[24] Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Frequently Asked Questions (FAQs), CMS (October 2021)

The Secretary could design VBPs for IRFs, LTCHs, SNFs and hospice providers similar to the Expanded HHVBP model by drawing upon existing quality measures that are already used for these models (Table 1). IRFs, LTCHs, SNFs and hospice providers all have QRPs in place that include measures in two of the three domains that are used for the Expanded HHVBP model—provider-reported assessment data and measures that are calculated by CMS based on claims. Measures in the third domain—patient survey data—are used in the hospice QRP. Surveys of patient experience have been developed for the other providers, but CMS has yet to introduce them for these QRPs. Of the four provider types, only SNFs are also subject to a VBP under which payments are adjusted for facilities' performance.[25] The Protecting Access to Medicare Act of 2014 (PAMA) required the implementation of a SNF VBP with a 2% withhold of SNFs' Medicare Part A payments to fund the program.[26] The program refunds 60% of the withhold as positive or negative payment adjustments.[27] (PAMA set an upper and lower limit for the withhold of 50% to 70% and gave the Secretary the authority to establish the final withhold percentage through rulemaking.) The payment adjustments began affecting SNF's payments as of October 1, 2018.[28] However, over the first three years of the program, these adjustments have been smaller than those implemented for the Expanded HHVBP model: -1.3% to +3.1% versus -5% to +5%.[29] In addition, CMS has modified various aspects of the SNF VBP due to the COVID-19 public health emergency.[30]

Table 1. Measures Reported by Home Health and Other Providers

	Provider-reported assessment data	Patient survey data	Claims-based measures
HHAs	Outcome and Assessment Information Set (OASIS)	Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)	• Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH) • Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use)
Hospices	Hospice Item Set (HIS)	CAHPS® Hospice Survey	• Hospice Visits in Last Days of Life (HVLDL) • Hospice Care Index (HCI) (a single measure comprising ten indicators of care processes occurring throughout the hospice stay)
IRFs	• Inpatient Rehabilitation Facility Patient Assessment	NA*	• Medicare Spending per Beneficiary (MSPB)–Post-Acute Care (PAC) IRF QRP • Discharge to Community–PAC IRF QRP

[25] What are the value-based programs? CMS.
[26] Protecting Access to Medicare Act of 2014 (April 2014)
[27] The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program, CMS.
[28] Ibid.
[29] Report to the Congress: Medicare and the Health Care Delivery System, MedPAC (June 2021)
[30] Fiscal Year 2022 Timeline Skilled Nursing Facility Value-Based Purchasing Program, CMS.

	Instrument (IRF-PAI) • Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)		• Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP • Potentially Preventable Within Stay Readmission Measure
LTCHs	• LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) • Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)	NA*	• Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) • Discharge to Community – Post-Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) • Potentially Preventable 30-Days Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
SNFs	• Minimum Data Set (MDS) 3.0 • Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)	NA*	• Medicare Spending Per Beneficiary – Post-Acute Care (PAC) SNF QRP • Discharge to Community - PAC SNF QRP • Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP • SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization

Notes: HHA (home health agency), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital), NA (not applicable), SNF (skilled nursing facility). While CMS has not yet included patient experience of care data in the IRF QRP or the LTCH QRP, CMS and the Agency for Healthcare Research and Quality have developed patient surveys of experience of care—the IRF Experience of Care Survey, the LTCH Experience of Care Survey, and the CAHPS® Nursing Home Survey.
Source: HMA analysis of data available from the Centers for Medicare & Medicaid Services.

The new VBPs could adopt rules similar to the Expanded HHVBP model for payment adjustments. First, an aggregated score similar to the TPS could be constructed for each provider type using available quality and resource use measures across the three measure domains. These aggregated scores of providers' performance relative to their peers could then be translated into a corresponding payment adjustment percentage with a maximum positive or negative adjustment of 5%. The new VBPs could also include withholds similar to the SNF VBP with a withhold range set in statute and specific withhold amounts determined by the Secretary and established through annual rulemaking.

Similar to the Expanded HHVBP model, the new VBPs could be monitored and adjusted through regular notice-and-comment rulemaking, as needed. A similar process already takes place on a regular basis for the QRPs with new measures developed and added to programs and other measures removed. As the programs gain experience, CMS could also make adjustment to the payment adjustment methodologies, such as shifting weight between individual measures or between attainment versus improvement on measures or adjusting the percentage of providers that are subject to the highest or lowest level of adjustments.

Proposed Policy

Medicare could implement a value-based purchasing (VBP) policy like the successful home health VBP model for inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), and hospice providers and direct the Secretary of the Department of Health and Human Services to withhold a portion of payments to fund the policies.

The effects on Medicare program spending of implementing VBPs for IRFs, LTCHs, SNFs and hospices similar to the Expanded HHVBP model would depend on the final features of the programs, the year each program went into effect, and other characteristics. Based on our analysis of Medicare data on hospitalizations, readmissions, post-acute care (PAC) utilization, hospice utilization, and non-hospice care associated with hospice patients for illustrative VBPs that would begin in 2025, we estimate that implementing VBP policies for IRFs, LTCHs, and SNFs, and hospice providers could yield more than $12 billion in Medicare Part A Trust Fund savings over 10 years.

Potential Savings

Implementing a VBP policy like the successful home health VBP model for IRFs, LTCHs, SNFs, and hospice providers beginning in 2025 could yield $12.4 billion in savings to the Medicare Part A Trust Fund over 10 years.

More importantly than the financial savings for the Medicare program, hospice and PAC VBP policies would improve the quality of care for beneficiaries who use these services. The VBP policies would be designed to reduce avoidable inpatient hospitalizations during or following a PAC episode. They would encourage greater coordination between institutional providers and physicians to ensure patient discharge needs are appropriately met. In addition, these policies would promote greater communication and data sharing between hospices and non-hospice providers and reduce utilization of non-hospice care during a hospice benefit period.

Potential Quality of Care Improvements

Implementing a VBP policy like the successful home health VBP model for IRFs, LTCHs, SNFs, and hospice providers would improve the quality of care that beneficiaries receive from these providers through the provision of financial incentives tied to performance.

Methodology and Assumptions

To estimate the effect of implementing a VBP policy for IRFs, LTCHs, SNFs, and hospice providers on Medicare Part A spending, I created an initial baseline estimate of all acute inpatient hospitalizations and institutional post-acute utilization and spending over a 10-year period, leveraging information from the 2021 Medicare Trustees Report as well as recent trends developed from the CMS Program Statistics.[31,32] I also developed a baseline estimate of hospice utilization and spending over the same period, using the same source material. These estimates account for the current expectation of Medicare Advantage (MA) enrollment patterns, annual increases in payments by the traditional, fee-for-service Medicare program, as well as the effects of the overall aging population.

I then determined the current rate of acute inpatient hospital utilization associated with Medicare beneficiaries with IRF, LTCH, and SNF stays, using the most recent national averages published in the Provider Compare data files by CMS.[33] These data indicate that 7% of IRF stays, 16% of LTCH stays, and 8% of SNF stays are associated with an inpatient admission to an acute-care hospital. Based on the evaluation reports of the original HHVBP demonstration, inpatient admissions are likely to decline as a result of a comprehensive scoring model that rewards providers for greater focus on care coordination.[34] I estimate that 3% of total spending on inpatient admissions will be eliminated due to similar VBPs for each provider type. Note that the evaluation found 2.8% reduction in inpatient spending, with "larger reductions in Medicare spending for [fee-for-service] beneficiaries receiving home health services in the three years of the model in which payment adjustments were applied (2018-2020) than in earlier years of the model (2016-2017)."[35]

I also created an estimate of non-hospice spending for hospice patients, using data from a recent OIG report that indicated this non-hospice spending was approximately 4% of total hospice payments.[36] Similar to the inpatient hospital admission impact, I assume that hospice providers

[31] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[32] CMS Chronic Conditions Data Warehouse, CMS.
[33] Provider data topics, CMS.
[34] Alyssa Pozniak, Marc Turenne, Eric Lammers, et al. Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model: Fourth Annual Report. (May 2021)
[35] Ibid.
[36] Medicare Payments of $6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight. A-09-20-03015. OIG (February 2022)

will be able to reduce total non-hospice spending by 3% due to the incentives associated with the new VBP.

I estimate that total payments to IRFs, LTCHs, SNFs, and hospice providers can be reduced by 0.5% each year due to two effects that the Secretary could monitor and adjust for on an annual basis: limited redistribution of a 2% withhold and the incentives associated with the new VBPs reducing the need for subsequent use of post-acute care following acute care hospital use. The evaluation of the HHVBP model found a 4% reduction in SNF spending. To the extent that the incentives associated with the new VBPs reduced spending by reducing the need for subsequent admissions to acute care hospitals and post-acute care, a greater share of the 2% withhold could be returned in the form of a greater share of providers receiving positive payment adjustments or providers receiving larger payment adjustments up to the 5% cap.

My estimated federal impact includes the impacts associated with the change in MA benchmarks and payments.