## Executive Summary

The Medicare Part A Trust Fund is projected to become insolvent by 2028.

August 2022

The new Expanded HHVBP model began January 1, 2022, with a pre-

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)<br>Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use) |
| **Hospices** | | | |

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.

*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.

*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.

## 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

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 .42 Tm0 g02 Tm0 g02 Tm0 g0249 gi1o reW* nBTF7 12 Tf1 0 0 1 123.62 598.42 Tm492 rm0 g0 G[(