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Putting "Value" Back In Value-Based Payment For Skilled Nursing Facilities

Recommendations from the Advancing Excellence in Long Term Care Collaborative

Abstract

The Advancing Excellence in Long Term Care Collaborative (AELTCC), a multi-stakeholder organization, convened a panel and participant discussion to discuss the challenges in implementing value-based payment (VBP) programs in long-term and post-acute care (LTPAC) settings and develop a set of recommendations for policy makers and payers developing VBP programs as the healthcare sector transitions from paying for volume to value. This white paper begins with a landscape overview of value-based payment programs relevant to skilled nursing facilities (SNFs) and clinicians. We then describe some of the challenges in implementing VBP from the SNF perspective and offer recommendations to ensure value is not lost such as explicitly including a participation track for LTPAC providers, featuring quality incentives that counterbalance the incentives to cut costs, leveraging quality measures that are appropriate for a SNF population and capture value for residents and families, and aligning requirements across programs to reduce provider burden.

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Introduction: Growth and spread of VBP as national policy focus

The topics of value-based purchasing and **value-based payment (VBP)** have dominated much discourse in health care over the past few years, and a proliferation of public and private initiatives have attempted to reap the financial and quality benefits of paying for the "value" of services provided instead of the "volume". This paper explores how the move from volume to value impacts skilled nursing facility (SNF) organizations, staff, and patients as discussed in a 2018 meeting of the Advancing Excellence in Long-term Care Collaborative. The paper also outlines key principles for VBP that may help ensure that "value" is appropriately defined and incentivized in emerging payment models.

The fee-for-service (FFS) payment system, exemplified in traditional Medicare, often ties a specific dollar amount to each service and offers the same payment regardless of patient outcomes or experience. This system incentivizes providers[*] to deliver more services and a higher intensity of care, thus increasing overall system costs without any assurance of benefit to patients. It also rewards good care and bad care with the same level of reimbursement. FFS may increase competition among providers and a "yours vs. mine" attitude toward patients that discourages collaboration.

Healthcare costs have more than doubled over the last 20 years, reaching 3.5 trillion dollars in 2017[1], and the United States has both the highest healthcare spending and higher prices for goods and services than other high-income countries.[2] In spite of its high expenditures, the US has not performed as well in measures of quality care as compared to many of these countries.[3,4]

These realities have led many stakeholders, including public and private payers, to attempt to reduce costs while maintaining or improving quality. Efforts intensified following the 2010 passage of the Affordable Care Act (ACA), which included provisions and authorized funding to improve the value of health care. The ACA established the Center for Medicare & Medicaid Innovation (CMMI) to test new care and payment models with a goal of improving quality of care and reducing spending for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.[5]

CMMI and others have attempted to realign incentives in care delivery through a calculated shift from a volume-based to a value-based payment and delivery system. In the healthcare world, "value" has been defined as outcomes (or quality) divided by costs.[6] Thus, a VBP model is a payment model that ties the amount of payment to the quality and/or cost of care provided. This deceptively simple definition leads to a plethora of questions surrounding both the definitions of "quality" and "cost", and the appropriate implementation of models that promise to produce a net positive for payers, facilities, clinicians, suppliers, and patients.

[**] Throughout this paper, we use "provider" to refer to any healthcare clinician, facility, organization, or other entity that delivers formal care to patients.

Landscape of VBP programs in Long Term and Post-Acute Care

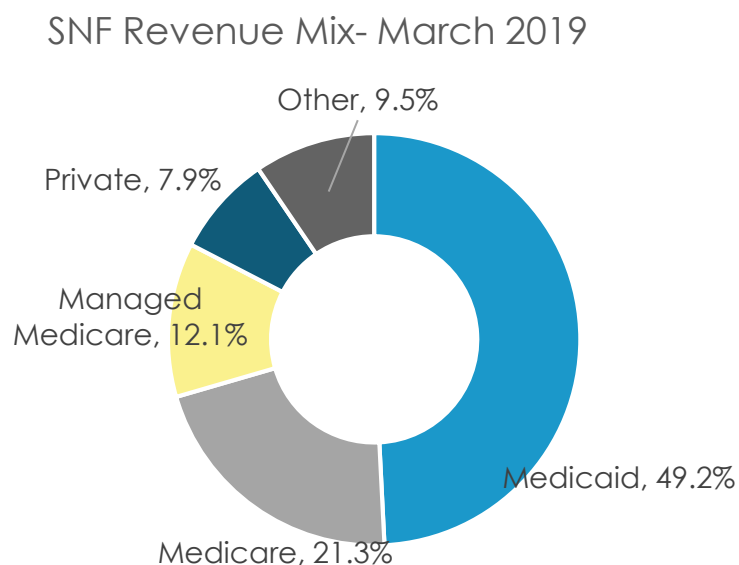As depicted in **Figure 1**, the Landscape of VBP programs encompasses Medicare payment programs, CMMI models and awards, Medicare Advantage and other health plan arrangements, state programs, and provider partnerships. Many of these programs impact SNFs directly or indirectly.

Figure 1. Landscape of VBP programs[7,8]

Medicare payment programs	State programs	CMMI models and awards

	Medicare Advantage and other health plan arrangements	Provider partnerships	
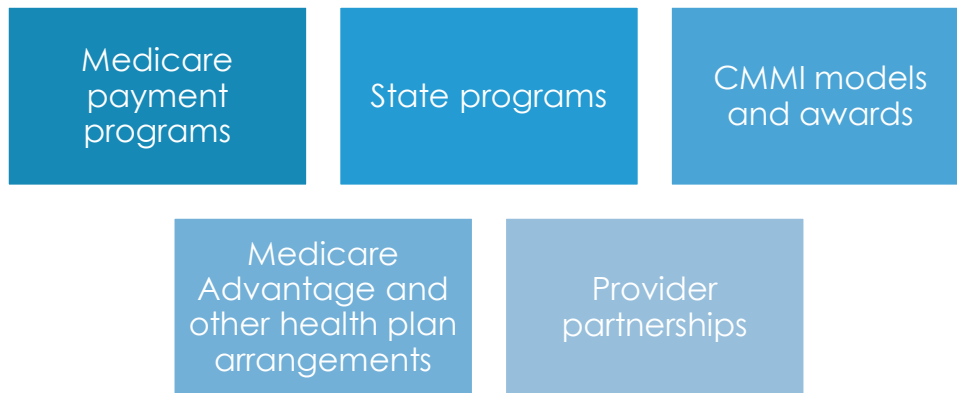
The discussion around VBP is often focused on traditional Medicare programs and CMMI models. However, traditional Medicare only accounted for 21% of skilled nursing facility (SNF) revenue mix in March 2019, with Medicaid at 49% and Medicare Advantage (MA) at 12% (see **Figure 2**).[9] Increasing MA penetration will present opportunities for more SNFs and other PALTC providers to engage in existing or future VBP programs with health plans. This section describes key payment programs with a quality or value component that are relevant to SNFs.

Figure 2: SNF Revenue Mix[9]

SNF Revenue Mix- March 2019

- Other, 9.5%
- Private, 7.9%
- Managed Medicare, 12.1%
- Medicaid, 49.2%
- Medicare, 21.3%

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Medicare programs

SNF QRP. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) requires the collection of standardized data elements and quality measures across PAC providers for public reporting.[10] In 2016, the Skilled Nursing Facility Quality Reporting Program (QRP) was implemented and tied the payment of individual SNFs to the submission of IMPACT Act required quality data.[11] While a pay-for-reporting program like the SNF QRP is not considered payment based on *value*, the move to standardize measures may support the implementation of value-based payment programs that include multiple provider types.

SNF Value-Based Purchasing. The first federal program that tied payment to performance for all Medicare-certified nursing homes is the SNF Value-Based Purchasing program, authorized by the Protecting Access to Medicare Act (PAMA) of 2014. Beginning in FY2019, the program withholds 2% of SNF Medicare payments and redistributes them in the form of "value-based incentive payments" (VBIP) based on each provider's performance on an all-cause risk-adjusted hospital readmission measure.[12] VBIPs range from a small increase in SNF rates to up to a 2% reduction.

PDPM. In July 2018, CMS finalized the Patient-Driven Payment Model (PDPM) for SNFs to be implemented for FY2020 in SNF Prospective Payment System.[13] This replaces the Resource Utilization Groups, Version IV case mix model for classifying patients during a Medicare Part A-covered stay.[14] The PDPM establishes a new classification system designed to shift the emphasis of payment from the volume of therapy services provided to patient acuity and care needs. CMS has framed this as a move toward a "more value-based, unified post-acute care payment system"', but the model itself does not include a quality component.[15]

MACRA and QPP. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to implement an incentive program for Part B services, now called the Quality Payment Program (QPP).[16] SNFs currently are not eligible to participate in the QPP, but eligible clinicians who bill for professional services under the Medicare Physician Fee Schedule participate in one of two value-based payment tracks.[17] This includes clinicians who see patients in SNFs, such as medical directors. The Merit-based Incentive Payment System (MIPS) adjusts clinician payment based on performance in four areas: Quality, Improvement Activities, Promoting Interoperability, and Cost.[18] The Advanced Alternative Payment Models (Advanced APMs) track allows clinicians to earn incentive payments by participating in an approved payment model that incorporates the use of certified electronic health record (EHR) technology, ties payment to quality measures, and requires the clinician to take on financial risk.[19]

MSSP. The Medicare Shared Savings Program (MSSP) allows providers and suppliers to set up Accountable Care Organizations (ACOs) and take responsibility for the costs, quality, and experience of a given population. The MSSP features several payment tracks that allow participants to take on varying levels of risk.[20] ACO participants include physicians and non-physicians, hospitals, and federally qualified health centers (FQHCS); SNFs are included as affiliates. In 2016, Genesis HealthCare ACO became the first long-term care ACO, focusing on a population of nursing facility residents with prolonged illness or chronic conditions.[21,22] The Genesis medical group entered the program on Track 1, enabling the ACO to share in savings earned without taking on risk for potential losses.[21,23]

CMMI models

Select CMMI models permit SNFs to share in the savings and/or losses from episode-based payment initiatives. Rather than paying each provider individually for the services it delivers, episode-based models often include a "bundled-payment" for all services and the opportunity to share in any program savings provided certain quality criteria are met. While care delivered in SNFs may be included in an episode, most CMMI models specify that the models must be led by hospitals or physician groups, who are also the locus of quality measurement and receive and distribute any savings.

BPCI. Beginning in 2013 and ending in 2018, the Bundled Payments for Care Improvement (BPCI) program established four models to test bundled payments. SNFs could participate in Models 2 and 3 but could only initiate episodes in Model 3. Both models created retrospective bundles wherein participants shared in a portion of the savings or losses calculated when total FFS expenditures were reconciled against a target price for the "bundle" of services.[24]

BPCI Advanced. BPCI Advanced continues to explore episode-based payment models from 2018-2023. Also a retrospective bundle, BPCI Advanced outlines 35 different clinical episodes (beginning in 2020 vs. 48 for the original BPCI Models 2 and 3) and qualifies as an Advanced APM under the QPP.[25] SNFs can participate in BPCI Advanced and bear financial risk, but cannot initiate episodes—a role reserved for acute care hospitals and physician group practices.

CJR. From 2016-2020, the CMMI Comprehensive Care for Joint Replacement Model (CJR) tests a bundled payment for an episode of care associated with hip and knee replacements. The episode includes care by hospitals, physicians, and PAC providers, but only hospitals can initiate episodes.[26] In this model, the hospital is the accountable entity to which any savings or losses accrue. This program is notable because the first two years of participation was mandatory for all Inpatient Prospective Payment System hospitals in selected service areas.

Next Gen ACO. Accountable Care Organizations (ACOs) are "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients."[27] The Next Generation ACO program draws on CMS experience with the Medicare Shared Savings Program and the Pioneer ACO Model to test whether allowing participants to take on high levels of financial risk can lower costs and improve outcomes.[28] The model permits ACOs to designate "Preferred Providers" along the care continuum, including SNFs that have a five-star rating of three or more. According to AELTCC members, some early Pioneer ACO adopters initiated value-based contracts with SNFs that began with a discounted Medicare FFS rate and required them to meet certain performance metrics related to process and quality in order to earn their way back to 100%, or in some limited cases, more.

Medicare Advantage and other initiatives

MA Contracts. Federal efforts to implement VBP have been accompanied by the efforts of Medicare Advantage (MA) Plans. MA plans may use quality in determining which SNFs to include in their networks or build quality incentives and penalties into their contracts with SNFs.

The impact of MA reimbursement on SNFs varies greatly state by state and county by county, with some counties with as high as a 60% MA penetration rate to other counties in the single digits. On average, nationally, 32% of Medicare beneficiaries were enrolled in MA in 2017; as these individuals age and seek SNF care, the MA population in nursing homes is likely to increase.[9,29]

SNPs. Some post-acute operators are beginning to become payers and operate Medicare Advantage Special Needs Plans (SNPs).[30] Institutional SNPs (I-SNPs) are tailored to the needs of residents who require the level of services similar to those offered in a nursing home, dual-eligible SNPs (DSNPs) focus on beneficiaries eligible for both Medicare and Medicaid, and chronic-condition SNPs (C-SNPs) apply to individuals with certain severe or disabling chronic conditions.[31,32] For SNPs, quality is measured through the MA Star Rating system, and plans with a 4-star rating or higher receive a quality bonus.[33]

Other initiatives. Many state Medicaid programs have also incorporated VBP initiatives in the form of payment targets or mandates, multi-payer models, and ACOs.[8] Finally, some provider organizations building networks and partnerships are establishing agreements that incorporate shared-savings, quality targets, and other VBP components.

An evolving landscape

The landscape of VBP is evolving rapidly, with new payment models, initiatives, and partnerships emerging as facilities, clinicians, payers, and policymakers try to navigate the shift from volume to value. For example, in April 2019, CMMI announced two new demonstration projects that offer new paths for VBP participation: Primary Care First and Direct Contracting.

- Under Primary Care First, advanced primary care practices to take on financial risk and are eligible for increased revenue if they meet quality targets. A second payment model focused on the serious illness population offers additional resources for practices to "take responsibility for high need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination."[34]
- The Direct Contracting model includes additional options for an expanded range of healthcare organizations to assume risk for various populations.[35]

CMMI is refining the details of these models, but both will include a quality component. Primary Care First focuses on primary care practices. Direct Contracting is designed for a broader array of organizations, but it is unclear to what extent SNFs will be welcomed as participants.[36]

As evidence of this evolving landscape, the percentage of total healthcare payments in the US (all payers) tied to quality via FFS add-ons (such as pay-for-reporting or pay-for-performance) increased from 15% in 2015 to 25% in 2017. The percentage of payments linked to alternative payment models (such as shared-saving/risk or population health models) increased from 23% to 34% during the same time (see **Figure 3**).[37,38]

Figure 3: Evolution of US Healthcare Payments
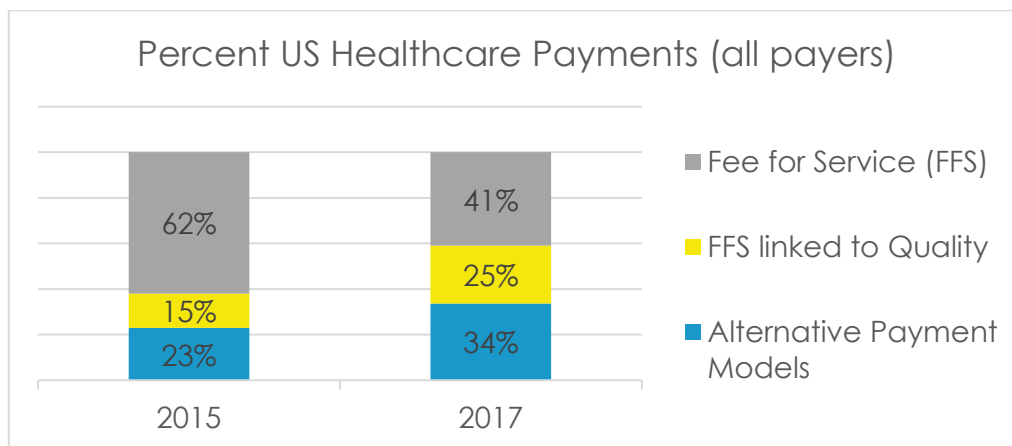
AELTCC Convening Session on VBP

The changing landscape of VBP in PALTC was the topic of a 2018 meeting of the Advancing Excellence in Long Term Care Collaborative (AELTCC), an organization of diverse stakeholders from the post-acute and long-term care services and supports industries that work together to define and address critical issues in health care.

The collaborative convened stakeholders representing a broad swath of perspectives to 1) identify key issues regarding the impact of payment models on quality and 2) outline potential actions to help address these issues. Some of the broad questions the convening sought to answer were:

- What are the quality consequences of moving toward VBP?
- Does the emphasis on "value" effectively align incentives among and between facilities, clinicians, payers, and patients?
- Are VBP programs measuring the right things?
- How can SNFs keep up with changes and assess opportunities?
- How is the pursuit of VBP arrangements impacting front-line staff?
- Does the move toward PDPM help move the SNF Prospective Payment System closer to a value-based model?

The meeting began with an overview of the transition from fee-for-service to VBP models and description of the evolving VBP landscape. After this level-setting and introducing the broad questions listed above, the meeting moved to a panel discussion on the impact of new payment models on quality in nursing homes. Six panelists presented the ways in which they are engaging in VBP, the challenges and opportunities from their organizations' perspectives (provider, payer, vendor, policy), and approaches they are taking to try to succeed in VBP. Throughout the panel, the AELTCC members in attendance asked questions and shared their thoughts and experiences. A full list of convening panelists and attendees is included in the **Appendix**.

The convening discussion revealed a complex VBP environment with many challenges stakeholders face in implementing VBP for SNFs. The following sections describe these challenges and AELTCC's recommendations for addressing them.

Challenges in Implementing VBP for SNFs

As VBP programs have been implemented and tested throughout health care, stakeholders have raised a number of concerns related to the definition of value and the risk of unintended consequences. Attendees outlined challenges to implementing VBP, many of which are specific to LTPAC providers (including SNFs) and patients:

- Lack of inclusivity
- Incentives for fewer needed services and risk of "cherry-picking"
- Payer-focused definitions of "value" and insufficient quality measures
- Provider burden
- Lack of interoperability

Lack of inclusivity

Many VBP programs exclude SNFs and other LTPAC providers from sharing in risk and savings or adopt a one-size-fits-all model which does not consider the idiosyncrasies of the population and regulations. This is critical because patients attributed to a program who are also served by LTPAC providers are often the sickest and most costly. When SNF patients are included in a bundle that excludes SNFs from sharing risk, SNF costs and efforts to improve quality increase value to the payer without any benefits to recognize those costs and efforts. For example, while CMMI models allow gains to be shared, SNFs/PAC providers often do not receive a portion of these gains even though their contributions to care redesign and improved quality contribute to the achieved savings.

Additionally, ACOs, I-SNPs, and other programs are frequently administered by clinicians, such as hospitalists, with little experience with geriatric care or SNF regulations. For example, SNF VBP programs from ACOs and MA plans often fail to appreciate the regulations and the resident rights in a SNF or nursing facility which differ from other institutional settings or conflict with plan requirements.

In order to cut costs, some payment model participants may seek to bypass SNF care or limit stays in ways that may be incompatible with care plan goals and timelines required in the regulations and encourage inappropriate early discharge to the community. For example, a 2019 study found that CJR cost savings were "nearly exclusively related to reductions in the use of post–acute care services in skilled nursing facilities and inpatient rehabilitation facilities."[39] Partners and program designers often presuppose that increased referrals to SNFs will be sufficient inducement for these providers to participate in VBP programs, but participating in some programs may result in fewer days of care and lower revenue.

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Incentives for fewer needed services and risk of "cherry picking"

Bundled payments, shared risk, and population health models may lead to the provision of fewer needed services because they offer a single dollar amount for a particular episode or population regardless of the actual cost to the providers. By reducing the number of services, providers may reduce their costs while receiving the same revenue. Without appropriate mechanisms to ensure continued quality, this could lead to poor outcomes for patients who would benefit from costly but effective treatment.[40] While many programs require providers to meet a threshold of performance on specific quality measures to retain savings, if these measures are not meaningful to patients and do not encompass the most important care outcomes, they may not suffice.

Reducing the number of services provided may also not address the root cause of high healthcare spending in the United States. Recent international analysis has found that higher rates of US healthcare spending are not associated with higher rates of utilization, but higher healthcare prices.[2,41]

As noted above, PDPM currently does not have built-in quality mechanisms to prevent SNFs from decreasing therapy services for residents who need them. Measures related to improved mobility and care planning around functional abilities are included in the Nursing Home Quality Initiative[42] (and the former is part of the Five Star calculation[43]), but these are not directly tied to payment. Likewise, two mobility measures and two self-care measures are included in the SNF QRP, but this is a pay-for-reporting program and does not penalize poor performance.[44]

VBP also has the potential to encourage participating providers to avoid high-cost and high-needs patients. This possibility can be mitigated by adjusting payments or quality calculations for patient acuity, socioeconomic status, etc. but this must be done carefully to prevent the appearance of providers "gaming the system".

These risks are especially critical for residents eligible for both Medicare and Medicaid. In a 2016 report to Congress, the Assistant Secretary for Planning and Evaluation (ASPE) found that, "in the context of value-based purchasing programs, dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that they examined and tested."[12] VBP programs may unintentionally 1) incentivize facilities and clinicians to avoid quality penalties by restricting access for dually eligible beneficiaries or 2) reduce the resources that "safety-net" providers have for caring for these populations.

While concerns of reducing services and "cherry picking" are not unfounded, VBP programs may be designed to incentivize delivering more appropriate services to high-needs patients. VBP programs that hold participants accountable for all or a portion of the entire Medicare spend for a beneficiary may incentivize participants to provide more preventative and supportive services that may help avoid higher costs and unnecessary services in the future. Some examples of such services include health screening, advance care planning, care coordination, person-centered activities, palliative care, collaboration with community-based service providers, and post-discharge telephonic support.

Payer-focused definitions of "value" and insufficient quality measures

Another criticism of VBP is that it passes costs on to patients. Measures of cost savings in shared savings or shared risk models often define value as reducing costs to the overall system, i.e., the program or health plan, not out-of-pocket costs to patients and families. Dual-eligible long stay nursing home residents may be particularly vulnerable when Medicare and Medicaid VBP programs do not align and leave gaps where needed services may not be covered.

One way a health system in an episode-payment model may try to reduce costs is by bypassing institutional PAC in favor of care in the home. If appropriate mechanisms are not in place to support home modifications, homemaker services, transportation, and other services needed to help sustain the patient in the home setting, those services may become out-of-pocket costs to the patient or result in poor outcomes. While the aforementioned study on CJR found no significant impact on select quality indicators[39], another recent study found that discharging patients from the hospital to home health care resulted in significantly lower Medicare payments, but higher hospital readmissions.[45]

Quality measures are implemented as a counterweight to cost-cutting but are sometimes narrowly focused on utilization. CMS has called the SNF VBP program an important move toward "rewarding better value, outcomes, and innovations instead of merely rewarding volume."[12] However, the only measure included was the SNF 30-Day All-Cause Readmission Measure.[46] While some studies have associated quality of nursing home care with readmission rates, others have found minimal evidence that readmissions are associated with other measures of nursing home quality.[47,48] Prior readmission rates are valid predictors of future readmissions[49], but readmissions itself is a measure of utilization that captures the volume of services to use as a convenient proxy for both the increase in expenditures from readmissions and the "value" of the services that precede each readmission.

> For VBP programs to effectively promote value, included quality measures must capture a broad spectrum of patient-centered quality care and outcomes and be weighted enough to motivate providers.

When measures of quality beyond utilization are used in programs, they are often not meaningful to facilities, clinicians, and patients. For example, VBP programs may assume a "medical model of care" and solely focus on clinical processes and physical outcomes. Long-stay SNFs are "home" for many patients, so programs should also encourage facilities and clinicians to meet the psychosocial needs of residents. For VBP programs to effectively promote value, included quality measures must capture a broad spectrum of patient-centered quality care and outcomes and be weighted enough to motivate providers. Measures must also capture processes and outcomes that providers can impact.

Provider burden

VBP programs rarely feature sufficient incentives to mitigate the organizational investment in infrastructure (including technology) and change management activities that facilities and clinicians must undertake to implement and succeed in these programs.

The proliferation of VBP programs can lead to confusion and additional burden as organizations struggle to keep up with attribution, data collection, and data submission requirements (including timeframes) that are not aligned across programs. For example, different payers in the same market may use different quality measures and have different requirements, even when they are contracting with the same providers and measuring the same concepts.

SNFs often track multiple metrics to facilitate efforts to improve quality of care for their residents. Measures included in VBP programs are often "lagging-indicators" and processes/systems must be established to identify and address the root causes of performance. If these measures do not capture meaningful concepts, focusing on them may shift resources away from measures that are more closely related to the daily needs and experiences of residents.

The effort to meet additional regulations and program requirements, coupled with financial penalties from the SNF Value-Based Purchasing Program, may increase already high financial pressures. SNFs that serve vulnerable populations, including dual-eligible beneficiaries, may also be resource-limited. If these facilities perform poorly on VBP, resources needed to invest in improvements may be further constrained. This may have the unintended impact of driving consolidation, change of ownership, and closure. Particularly in rural areas, this may also result in reduced access to long-term care services.

Lack of Interoperability

Another challenge that may hinder SNFs ability to fully deliver value-based services is the lack of interoperability. Even if SNFs have invested in and deployed an EHR, that does not guarantee the ability to electronically exchange data with other partners as current infrastructure does not fully support the exchange. When multiple settings are included in a VBP model, the ability to track a patient throughout the continuum and share critical care information across provider settings is a critical component to giving patients needed care and improving outcomes.

The IMPACT Act included "Transfer of Health Information and Care Preferences when an Individual Transitions" as one of the domains for quality measurement and improvement, and two measures in this domain will be adopted into the SNF QRP for FY2022 (with data collection beginning October 2020). These measures will assess the transfer of a current, reconciled medication list to both the subsequent provider and to the patient or representative at the time of discharge.[50] The transfer of information can occur verbally, on paper, or electronically, but technology could certainly support this process. However, because these measures are incorporated in an accountability program for SNFs, they put the focus for interoperability on PAC providers, whereas effective electronic transfer of this information would also require investment from technology vendors that serve each care setting.

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AELTCC Recommendations for Improving VBP Programs

Participants in the AELTCC convening session advanced several recommendations to address the challenges discussed above. These are summarized in **Figure 4** and described below.

Figure 4: Summary of recommendations for improving VBP Programs

Develop more inclusive VBP programs that have explicit roles or tracks for SNFs and address the PA and LTC populations when planning for program implementation and ongoing administration.

Counter incentives to reduce costs at the expense of access and quality by building in risk adjustment, relevant quality measures, and other incentives.

Move from payer- to patient- focused definitions of "value" by measuring quality processes and outcomes beyond utilization and including SNF residents in measure development and program design.

Minimize provider burden through aligned requirements and resource support.

Develop more inclusive programs

VBP program designers—including CMS, CMMI, state programs, private payers, and even other providers—should develop programs to be led by SNFs and other LTPAC providers and explicitly address the role of LTPAC providers in VBP programs designed for other care settings, such as physician and hospital settings.

More inclusive programs would allow LTPAC providers to take on risk and benefit from shared savings in programs that include their patients. Quality in programs that include SNFs or impact their patients should contain measures that are appropriate and meaningful to a LTPAC population. If LTPAC providers are held accountable for delivering value in CMMI models through certain performance measures, they should share in the financial rewards of achieving the desired performance in those models and their patients should benefit from care and quality improvements.

Where LTPAC providers are held accountable for patient outcomes via VBP arrangements, regulatory flexibility can support efforts to achieve better outcomes. Program designers can also promote better care by incorporating waivers to some regulations, reporting requirements, and reimbursement restrictions. Several existing programs, such as MSSP and BPCI Advanced, include waivers for the SNF 3-day inpatient requirement or expanding the use of telehealth.[51,52] Programs can also consider waiving preauthorization requirements and requirements for physician visit frequency to increase SNF flexibility to individualize care to resident needs.

Health plans administering VBP programs and SNFs entering into VBP contracts should make plans for addressing and supporting dual-eligible beneficiaries who will be included in more than

one payment model. Organizations, such as hospitals, who are currently leading VBP programs impacting Medicare beneficiaries should employ geriatric-trained doctors, nurse practitioners, and physician assistants to coordinate care in ways that are sensitive to the needs of the LTPAC population.

Counter incentives to reduce costs at the expense of access and quality

Program designers should leverage financial mechanisms to counteract unintended consequences and unrestrained cost cutting. Some of these include:

- Building appropriate risk adjustment into VBP programs to help defray the costs associated with high risk, high needs patients and avoid incentives to "cherry-pick".
- Selecting quality measures carefully to encompass meaningful patient outcomes.
    - CMS could include VBP component based on current SNF QRP functional outcome measures to counterbalance PDPM incentives to decrease therapy delivery.
    - For example, the "Change in self-care score", "Discharge self-care score", "Change in mobility score", and "Discharge mobility score" measures are included in the SNF QRP, but performance is not attached to payment.[43] If these measures are sensitive enough to capture provider differences in performance and change over time, they may be good candidates for inclusion in future VBP.
- Placing a greater proportion of the provider's reimbursement or financial reward at risk to be earned based upon quality performance.
- Recognizing the critical role that services such as advance care planning, care coordination/navigation, telephonic support, palliative care, and person-centered activities play in improving outcomes and lowering costs for the patient by financially incentivizing providers to invest time and resources in these services at all levels.

Move from payer- to patient- focused definitions of "value"

Program designers should ensure VBP programs have a component that specifically captures "value" and is linked to quality outcomes rather than focusing solely on savings or utilization. In some cases, a budget neutral program with better outcomes may represent better value for patients, providers, and payers than a program that demonstrates cost savings.

To address insufficient quality measures, program designers should add measures to VBP programs that are meaningful to patients, facilities, and clinicians and include clinical outcomes, patient-reported measures of outcomes and experience, process measures that capture patient-centered care, and the care and outcomes expected from the "social model" of care. Specifically, CMS should expand the SNF VBP program to include measures beyond the current readmission measure.

A key component for making measures meaningful to patients is including patients in measure development and program design processes. CMS describes including patients in its Measures Management System Blueprint for quality measures development.[53] Measure developers and program designers should deliberately include SNF residents and their families in conversations

about how to measure value and what outcomes are most important to track and improve. This should occur for programs that impact them, even when SNFs are not the primary focus of the program.

Minimize provider burden

Program designers can take several actions to reduce the burden on SNFs and other providers for implementing and administering VBP programs:

- Follow the "patients over paper-work" principle promoted by CMS[54] when determining VBP documentation requirements and align documentation and justification of care requirement across programs.
- Align measures used across payers and programs and select National Quality Forum-endorsed measures when possible.
- Simplify documentation, data collection, and submission requirements and processes (e.g., for MDS – section G and GG) and align these requirements across payment programs, Five-Star reporting, and the SNF QRP.
- Use national measures when designing state Medicaid programs and align with Medicare requirements to improve care for dual-eligible beneficiaries. In the cases where states have a more comprehensive measure set or appropriate measures, state policymakers should collaborate with CMS to promote inclusion of those measures in national programs.
- Offer financial incentives and other resources to help support program implementation and administration. This could include funding to incentivize SNFs to invest in technology to enable data analytics and data sharing including EHR systems. It could also be accomplished through providing SNFs additional recognition or credit via quality measures if SNFs can exchange data.

Conclusions

The AELTCC stakeholders at the convening had diverse experiences with value-based programs but shared a desire for programs that align incentives to improve care for SNF residents. In the rapidly evolving landscape of quality and VBP, AELTCC stakeholders recommended that future VBP programs:

- explicitly include a participation track for LTPAC providers or specify their roles,
- create financial incentives related to quality and outcomes comparable to payment incentives to lower care costs to encourage desired care redesign,
- leverage quality measures that are appropriate for the SNF population and meaningful for residents and families, and
- align with other program requirements to reduce provider burden.

Incorporating these principles during program design can increase the ability of SNFs and other LTPAC facilities and clinicians to engage in value-based programs and advance the triple aim of reducing system costs, improving patient experience of care, and improving the health of the LTPAC population and beyond.

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Appendix: Convening Panelists and Attendees

AELTCC thanks the following participants for sharing their time and expertise during our convening. Affiliations were accurate as of June 19, 2018, when the meeting took place in Washington, D.C.

Panelists	
Victoria Walker	The Evangelical Lutheran Good Samaritan Society
Richard Feifer	Genesis HealthCare, Genesis Physician Services (GPS), Genesis ACO
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