Nursing Home Value-Based Purchasing Demonstration

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Background

- NHVBP is a CMS “pay-for-performance (P4P)” initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing homes.
  - CMS will provide financial incentives to nursing homes *that* demonstrate certain high standards for providing quality care.
  - Approach is to assess nursing home performance based on selected performance measures and make additional payments to those nursing homes that achieve the best performance or the most improvement based on those measures.
  - Payment pool for each State will be determined based on Medicare savings that result from reductions in Medicare expenditures, primarily from reductions in hospitalizations.
- NHVBP is one of several CMS P4P initiatives and is consistent with Institute of Medicine (IOM) recommendation to align payment incentives with quality improvement.
  - Current payment systems do not reward or promote quality and may at times reward poor performance.
  - Incentive payments can encourage providers to improve the quality of services they provide.

Overview of NHVBP Demonstration

- State selection
  - CMS will select up to four States to host the demonstration and may also select 1-2 alternate States.
- Nursing home participation
  - Participation will be voluntary.
  - Nursing homes will be required to submit an application in order to be considered for the demonstration.
  - Interested nursing homes will be randomly assigned either to the demonstration or to a control group after stratifying the nursing homes based on certain characteristics.
  - We will select 50 nursing homes in each State to participate in the demonstration and will assign the same number of nursing homes to the control group.
- Residents
  - Demonstration will include all Medicare-eligible nursing home residents, many of whom are dual eligible and for whom Medicaid is the primary payor.

Performance Measures

- Core set of performance measures to be used in the first year of the demonstration; additional measures are not included initially but may be added for the second year, pending the results of ongoing research and development efforts.
- Performance measure categories
  - Staffing (levels and stability): 30 points
  - Potentially avoidable hospitalizations: 30 points
  - Outcomes from State survey inspections: 20 points
  - Quality measures (derived from the MDS): 20 points

Staffing Performance Measures

- Staffing levels and stability
  - Staffing is a vital component of quality care for nursing home residents.
  - Considerable evidence of a relationship between staffing levels/stability and resident outcomes
    - Phase I and II CMS Staffing Studies: Found that staffing levels below certain levels placed residents at increased risk of hospitalizations and poor quality outcomes.
    - CMS Staffing Quality Measure Study: Found that a high priority should be placed on measures of RN staffing levels and RN turnover.

Staffing Performance Measures

- Staffing measures
  - Registered nurse/ Director of Nursing (RN/DON) hours per resident day;
  - Total licensed nursing hours (RN/DON/licensed practical nurse) per resident day
  - Certified Nurse Aide (CNA) hours per resident day; and
  - Nursing staff (RN, LPN, CNA) turnover rate
- Agency staff count 80% in staffing level measures.
- Case mix adjustment of staffing level measures
  - Differences in resident acuity affect the staffing levels needed to care for residents, suggesting a need for case mix adjustment.
  - Case mix model to be developed, based on case mix weights from the CMS STRIVE study, a national time measurement study that will be used to update the Medicare prospective payment system.

Data Source for Staffing Performance Measures

- Payroll data will be the source for nursing home staffing and turnover measures.
- Participating nursing homes will submit payroll data quarterly.
- Staffing measures calculated from payroll data will be used due to their accuracy and potential to be audited.
- Data collection specifications for the payroll data are on the CMS web site

Potentially Avoidable Hospitalizations

- Previous studies suggest that careful management of certain kinds of conditions may reduce hospitalization of nursing home residents and that substantial portion of hospital admissions of nursing home residents are potentially avoidable.
- Performance measure of potentially avoidable hospitalizations gives nursing home a direct incentive to reduce the rate of hospitalizations, which would reduce Medicare expenditures.

Defining Potentially Avoidable Hospitalizations

- Defined as hospitalizations with any of the following diagnoses:
  - Heart failure
  - Respiratory infection
  - Electrolyte imbalance
  - Sepsis
  - Urinary tract infection
  - Anemia (long-stay residents only)
- Includes transfers directly from the nursing home to the hospital and admissions to the hospital within three days after NH discharge.
- Medicare Advantage enrollees are not included in the measure because Medicare claims data are not available.

Specification of Hospitalization Measure

- Separate measures for short-stay and long-stay residents
  - Short-stay measure: Measure of hospitalization rates per *episode*.
  - Long-stay measure: Measure of hospitalization rate per *resident day*.
- Scoring rules:
  - Scoring rules intended to minimize the incentive for homes to avoid appropriate hospitalizations, such as not awarding additional points for nursing homes that are above the top quartile in their performance on this measure.
  - Relative weight of short and long-stay hospitalization rates depends on facility-specific mix of residents.

Hospitalization Measure: Risk Adjustment

- Risk-adjustment models build on the risk-adjustment models developed for the short-stay population as part of the CMS staffing studies.
- Covariates include measures related to demographics, function, resuscitation orders, cognitive performance, and clinical conditions

Selection of MDS-Based Quality Measures

- Quality measures (QMs) from Federal Minimum Data Set (MDS)
  - Use of QMs consistent with IOM recommendation to link financial incentives to patient outcomes.
- Measure selection
  - Use a subset of previously developed and validated MDS-based quality measures (QMs) and quality indicators (QIs) .
  - Measures cover a broad range of functioning and health status in multiple care areas.
  - Measures selected based on reliability, extent to which measure is under the facility's control, statistical performance, and policy considerations.

MDS-Based Quality Measures

- Chronic care (long-stay) residents: Use five of the QMs posted on Nursing Home Compare:
  - % of residents whose need for help with daily activities has increased;
  - % of residents whose ability to move in and around their room got worse;
  - % of high-risk residents who have pressure ulcers;
  - % of residents who have had a catheter left in their bladder; and
  - % of residents who were physically restrained.
- For each of these measures, the exclusion criteria, minimum required sample, and risk adjustment methodology would be the same as used in the publicly reported measures.
- Post-acute care (short-stay) Residents:
  - % of residents with improving level of Activities of Daily Living (ADL) functioning;
  - % of residents who improve status on mid-loss ADL functioning; and
  - % of residents experiencing failure to improve bladder incontinence.

MDS-Based Quality Measures: Scoring Rules

- Weighting of measures depends on types of residents at the facility:
  - Facilities with both short and long-stay residents: Points will be allocated equally across all measures
  - Facilities with only long-stay residents: Points allocated equally across the 5 long-stay measures.
  - Facilities with only short-stay residents: Points allocated equally across the 3 short-stay measures.
  - If measures need to be imputed, their values will be based on the average of the demonstration nursing homes in the State.
- When MDS 3.0 is implemented, CMS will review this domain and consider revisions to the measures and point allocation method.

State Survey Inspections

- Outcomes from State inspection survey
  - All nursing home that participate in Medicare or Medicaid must be certified as meeting Federal requirements through nursing home surveys, which occur on a regular basis (on average once every 12 months).
  - On-site, independent observation of nursing home quality.
- Survey deficiencies are used in two ways: as a performance measure and as a screening measure.
  - Performance measure: Survey compliance score
    - Deficiencies are assigned points, based on scope and severity
    - Also consider number of revisits required to correct deficiencies
  - Screening measure: Facilities with substandard quality of care deficiency during the demonstration year are ineligible for an incentive payment.

State Survey Inspections

- For each nursing home, a survey inspection value is calculated based on the scope and severity of deficiencies and the regulatory areas where deficiencies occur.
  - Only consider health deficiencies (F-tags), not life safety.
  - Include deficiencies resulting from complaint surveys
  - Also consider number of revisits needed to confirm correction of deficiencies
- Calculate a total value based on deficiencies and revisits. A lower value corresponds to a higher performance score.

State Survey Inspections: Scoring Rules

- Weights for different types of deficiencies:
  - A, B and C level: 0 points
  - D level: 4 points
  - E level: 8 points
  - F level: 16 points (20 points if for substandard quality of care)
  - G level: 20 points
  - H level 35 points (40 points if for substandard quality of care)
  - I level 45 points (50 points if for substandard quality of care)
  - J level 50 points (75 points if for substandard quality of care)
  - K level 100 points (125 points if for substandard quality of care)
  - L level 150 points (175 points if for substandard quality of care)
- Weights for revisits (no points for first revisit)
  - Second: 50 points
  - Third: 75 points
  - Fourth: 100 points

Other Potential Performance Measures

- There are several potential performance measures that require further development work but that may be possible to include beginning in the second year of the demonstration.
  - Resident experience with care surveys
    - Use of survey
    - Resident satisfaction (based on a standard survey such as Nursing Home CAHPS)
  - Staff immunization rate
- CMS plans to continue conducting research on these and other measures for possible future application.

Scoring Rules and Linking Performance to Payments

- Considerations for scoring rules
  - Thresholds for individual measures or a continuous scoring system?
  - Base on overall performance or performance on individual measures?
  - Relative performance or pre-determined thresholds?
- Considerations for linking performance to performance payments
  - What percentage of participants should receive performance payments?
  - Balance between rewarding high performance and improvement over time.
- A continuous scoring system is used, with points allocated proportionately based on facility rank within the State (i.e., best performer receives maximum number of points for the measure, worst receives zero points)

Performance Payments: Eligibility

- Performance payments will be based on the overall performance score rather than the scores on individual performance measures or categories of measures.
- Eligibility for performance payments
  - Facilities in the top 20% in terms of overall performance (across all measures) qualify for a performance payment, as do those in the top 20% in terms of improvement relative to the baseline period.
  - Overall performance must be at least at the 40th percentile (ensures that no performance payments are made to nursing homes with overall poor performance).
  - Nursing homes with hospitalization rates above the comparison group median or significantly higher than base year rate will be ineligible for a performance payment (ensures that qualifying nursing homes contribute to reduced hospitalization rates, thus savings).

Performance Payments: Allocation

- Top 10% in terms of performance or improvement receive a performance payment that is 1.2 times higher than the next 10%.
- Nursing homes cannot receive performance payments for both performance level and improvement.
  - If a nursing home qualifies based on both performance level and improvement, it receives the higher of the two performance payments for which it qualifies.
- Payment pool distributed such that the amount of the performance payment is the same whether a nursing home qualified as a top performer or improver.
- Payments weighted based on nursing home size

Determining the Size of the Payment Pool

- Demonstration must be budget neutral to the Medicare program
- Size of the performance payments depends on the Medicare savings generated by demonstration participants in each State.
  - CMS anticipates that certain avoidable hospitalizations may be reduced as a result of improvements in quality of care.
  - By reducing the number of hospitalizations, the demonstration is also expected to lead to reductions in Medicare SNF expenditures.
  - Result is a pool of savings to the Medicare program that can be used to fund performance payments

Calculating Medicare Savings

- Use experiences of control group nursing homes to estimate Medicare savings.
- Compare certain risk-adjusted Medicare Part A and B payments per resident between the experimental and control groups.
  - Medicare program savings estimated by comparing the pre-post change in risk-adjusted Medicare expenditures for demonstration and comparison facilities, using resident expenditures per day or per episode.
  - Savings calculation is made across all demonstration facilities in a state, not for individual nursing homes.
  - Risk-adjustment will be used to adjust for differences in health status between beneficiaries at demonstration and control facilities.
- Similar to approach used in CMS Physician Group Practice and Home Health P4P demonstrations.

Determining Size of Performance Payment Pool

- Performance payments will be made from payment pools that will be calculated separately for each State.
  - The difference in Medicare expenditures between demonstration and control group homes will be calculated. This difference must exceed a threshold of 2.3% of Medicare Part A and B expenditures in order for the payment pool to be funded. This avoids paying for differences in the change in Medicare expenditures that may be due to chance.
  - Savings above the threshold will be divided, with 80% going to the payment pool and 20% retained by the Medicare program.
  - The size of the payment pool cannot be larger than 5 percent of control group Medicare Part A and B expenditures. Any amount above this cap will be retained by Medicare.
  - If no Medicare program savings are achieved, no performance payments are made to any facilities.
- Methodology ensures that no nursing home faces payment reductions as a result of participating in the demonstration.

Impact on Medicaid costs

- Demonstration may result in an increase in Medicaid expenditures.
  - Anticipated reduction in hospitalizations and Medicare SNF stays will lead to an increased number of Medicaid-covered days in the nursing home for long-stay residents (since Medicaid would likely be the primary payer).
- The size of the impact depends on state-specific policies (e.g., payments to hold the bed and coverage for Medicare deductibles).