Nursing Home Value-Based Purchasing Demonstration

Overview

- Objective: To improve the quality of care furnished to all Medicare beneficiaries in nursing homes.

- Approach

  - Assess nursing home performance based on selected performance measures.

  - Make annual payment awards to those nursing homes that achieve the best performance or the most improvement based on the 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.

Framework

- A three-year demonstration beginning in summer 2009.

- Demonstration states: Arizona, Mississippi, New York, and Wisconsin

- Nursing homes within these states are being solicited to participate in the demonstration

  - Solicitation letters have been mailed to nursing homes in these states.

  - Participation will be voluntary.

  - Nursing homes will be required to submit an application in order to be considered for the demonstration.

  - Application kits are posted at: www.nhvbp.com

  - Interested nursing homes will be randomly assigned either to the demonstration or to a comparison group after stratifying the nursing homes based on certain characteristics.

Features

- The demonstration has several significant features:

    - It includes all Medicare beneficiaries residing in nursing homes, including long-stay residents.

    - Both freestanding and hospital-based nursing homes are eligible to participate.

    - It rewards both levels of performance and improvement in performance over time, so that all participating nursing homes may qualify for a payment award, regardless of initial performance level.

    - It is designed to be budget neutral.

Budget Neutrality

- The NHVBP demonstration will be budget neutral

  - Within each State, a pool of Medicare savings must be generated before payments can be made.

- In each State, CMS will randomly assign nursing homes that apply to participate in the demonstration to either the demonstration or a comparison group.

  - About 50 nursing homes in each State will be assigned to each group.
  - The size of the payment pool in each state will be determined based on the estimated Medicare program savings achieved by demonstration homes in each state.

- Higher quality of care is expected to result in fewer avoidable hospitalizations, yielding savings to Medicare.

Performance Measures

- Each year of the demonstration, CMS will calculate a score for each nursing home based on performance on four domains:

    - Nurse staffing
    - Rates of potentially avoidable hospitalizations
    - Outcome on selected MDS-based quality measures
    - Results from State survey inspections

Staffing Performance Measures

- There is evidence that low staffing levels and high nursing staff turnover compromise the quality of care of nursing home residents.

- 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

- Staffing measures will be adjusted for case mix differences.

- Staffing measures will be calculated from payroll data submitted by nursing homes.

  - Participating nursing homes will submit payroll data quarterly.

Potentially Avoidable Hospitalizations

- Previous studies suggest that careful management of certain kinds of conditions may reduce hospitalization of nursing home residents and that a substantial portion of hospital admissions of nursing home residents are potentially avoidable.

- Defined as hospitalizations with any of these diagnoses: CHF, respiratory infection, electrolyte imbalance, sepsis, urinary tract infection

  - Includes anemia for long-stay residents only

- Separate measures for short and long-stay residents.

- Includes transfers directly from the nursing home to the hospital and admissions to the hospital within three days after NH discharge.

- Scoring rules intended to minimize the incentive for homes to avoid appropriate hospitalizations.

- Hospitalization measure is risk-adjusted.

MDS-Based Quality Measures

- Use of MDS-based quality measures aligns payment incentives with achievement of better outcomes

- We will use a subset of already-developed and validated MDS-based quality measures (QMs).

  – The 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.

- Initially, MDS 2.0-based measures will be used. When MDS 3.0 is implemented, CMS will review this domain and consider revisions to the measures and point allocation method.

- Weighting of measures depends on types of residents at the facility.

MDS-Based Quality Measures (Continued)

- 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.

State Survey Inspections

- Outcomes from State survey inspections

  – Health inspection surveys provide a broad perspective of the quality of care furnished by nursing homes.

  – They are an on-site, independent observation of nursing home quality.

- Survey deficiencies are used in two ways: as a performance measure and as a screening measure.

  – Screening measure: Facilities with substandard quality of care deficiency are ineligible for an incentive payment for the year.

  – Performance measure:

    - Deficiencies are assigned values, based on scope and severity

    - Also consider number of revisits required to correct deficiencies

    - Similar to system used in CMS 5-Star Rating system, except that only the most recent survey is considered.

Other Potential Performance Measures (Developmental Measures)

- There are several promising 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 (e.g., based on Nursing Home CAHPS)
  - Staff immunization rate

- CMS plans to continue conducting research on these and other measures for possible future application.

Scoring Rules

- Weights for performance measures

  - Staffing: 30 points (10 point for RN staffing, 5 points for licensed staffing, 5 points for CNA staffing, 10 points for turnover)

  - Potentially avoidable hospitalizations: 30 points

  - Survey deficiencies: 20 points

  - Resident outcomes: 20 points

- A continuous scoring system is used, with points based on facility relative performance within the state (i.e., based on facility percentile).

  - This method was selected because it avoids the "cliff effect" and is considered fairer.

  - Points allocated proportionately based on facility rank within the State (i.e., best performer receives maximum number of points for the measure, worst performer receives zero points)

Measuring Medicare Savings

- Size of the performance payments depends on the Medicare savings generated by demonstration participants in each State.

  – CMS anticipates that certain hospitalizations may be reduced as a result of improvements in quality of care.

  – Result is a pool of savings to the Medicare program that can be used to fund performance payments

  – Similar to approach used in CMS Physician Group Practice and Home Health P4P demonstrations.

- Medicare savings will be calculated based on the difference in the change in Medicare expenditures between demonstration and comparison groups.

  – Use comparison group to estimate what certain risk-adjusted Medicare expenditures (for certain Medicare expenditures) for demonstration nursing homes would have been in the absence of the demonstration.

  – Calculate difference between actual and predicted expenditures for demonstration group in each State.

Determining the Size of the Payment Pool

- Apply a shared-savings approach to estimated Medicare savings:

  - Threshold: The amount that exceeds 2.3% of total Medicare expenditures is considered Medicare savings.

  - Amounts above the threshold are divided, with 80% used to fund performance payments and 20% retained by CMS.

  - The size of the performance pool cannot exceed 5% of total Medicare expenditures. Any savings above this cap will be retained by CMS.

  - If no Medicare program savings are achieved, no incentive payments are made to any facilities, regardless of performance.

- Methodology ensures that no nursing home faces payment reductions as a result of participating in the demonstration while maintaining budget neutrality.

Eligibility for Performance Payments

- Performance payments will be based on the overall performance score rather than the scores on individual performance measures or categories of measures.

- Eligibility for incentive payments

    - Facilities in the top 20% in terms of overall performance (across all measures) qualify for an incentive 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. (This ensures that qualifying nursing homes contribute to savings).

Allocation of Performance Payments

- Top 10% in terms of performance or improvement receive a higher incentive payment that is 1.2 times higher than the next 10%.

- Payment pool is allocated equally between top performers and improvers.

- Payments weighted based on nursing home size

- Nursing homes cannot receive incentive payments for both performance level and improvement.

NHVBP Application Process

- One-page cover sheet

    - Mail <u>signed</u> form to Abt Associates

- Data collection form

    - Email Excel spreadsheet or mail CD to Abt

- Data elements

    - General facility information

    - Resident census information

    - Payroll data

    - Agency staff information

    - Developmental measures:

        - Staff immunizations
        - Use of resident care experience surveys

Timeframe

- Applications must be <u>sent</u> by May 1, 2009.

- Technical assistance is available to all applicants.

  - Email NHVBP@cms.hhs.gov

- Award letters will be sent to nursing homes selected for the demonstration around June 1, 2009.

  - Includes Special Terms and Conditions

- Awardees must send acceptance reply to CMS within 30 days of date of award letter.

Data Submission Requirements: Payroll Data

- 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.

Payroll Data Elements

- Medicare Provider Number

- Employee identification number

  – Unique to the employee at the facility.

  – Should not include SSN or any other personally identifiable information.

  – Should not change if the employee is promoted.

  – May change if the employee leaves the facility but is rehired at some later date.

- Employee start date

  – Date the employee started employment with the facility in her/his most current position

- Employee job category

  – Regardless of classification used by the facility, each nursing staff employee needs to be categorized into one of: 1) DON, 2) RN, 3) LPN, or 4) CNA.

Payroll Data Elements

- Pay period dates

  - Pay period **start date** is the first day of the pay period being reported.

  - Pay period **end date** is the last day of the pay period being reported.

  - Pay periods could be 7 days, 14 days, bi-monthly, or monthly in length.

  - Consecutive pay periods should not overlap.

- Employee hours reported

  - Number of hours actually worked at the facility (can be any number, including fractions).

  - Nonproductive hours for sick, vacation, holidays, disability, administrative, etc. (can be any number, including fractions).

Conclusions

- The NHVBP demonstration has several noteworthy features:

  - It includes all Medicare beneficiaries.

  - The performance measures reflect various dimensions of quality

  - By rewarding both the level of performance and improvement, all demonstration nursing homes can potentially qualify for a performance award.

- For more information on the demonstration, go to

  www.nhvbp.com