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NURSING HOME VALUE-BASED PURCHASING DEMONSTRATION

FACT SHEET AUGUST 2009

Background

The Nursing Home Value-Based Purchasing (NHVBP) Demonstration is the Centers for Medicare & Medicaid Services (CMS) "pay-for-performance (P4P)" initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing homes.

Under this demonstration, CMS will provide financial incentives to nursing homes that demonstrate delivery of high quality care or improvement in care. CMS anticipates that certain avoidable hospitalizations will be reduced as a result of improvements in quality of care. The reduction of avoidable hospitalizations and subsequent skilled nursing facility (SNF) stays is expected to result in savings to Medicare that will be used to fund the incentive payments. The demonstration will include all Medicare beneficiaries who are in a nursing home (i.e., those that receive only Part B benefits as well as those that receive Part A benefits, many of whom are also eligible for Medicaid).

The approach will be to assess the performance of nursing homes based on selected quality measures, and then make "performance" payments to those nursing homes that achieve the best performance or the most improvement based on those measures. Performance will be assessed in the following four domains: staffing, appropriate hospitalizations, outcome measures from the minimum data set (MDS), and survey deficiencies from State health inspections.

The demonstration will include volunteer nursing homes in three "host" States: Arizona, New York and Wisconsin. A payment pool will be determined each year for each State based on Medicare savings that result from reductions in the growth of Medicare expenditures, primarily from reductions in hospitalizations. We anticipate that higher quality of care will result in fewer avoidable hospitalizations, resulting in decreases in Medicare-paid hospitalizations and subsequent skilled nursing home stays.

Demonstration Status

CMS solicited nursing homes in the host States in March, 2009. Nursing homes submitted applications to CMS that included nurse staffing data for the period January through March 2009. The applicants used payroll data as the source of the staffing information. In June, CMS selected a subset of the applicants to participate in the demonstration. To estimate the savings pool for each State, CMS either randomized the applicants or selected a comparison group of nursing homes in each State that matches the characteristics of the participating nursing homes in that State.

The demonstration began July 1, 2009. The number of participating nursing homes in each State is as follows: Arizona - 41 homes; New York - 79 homes; Wisconsin - 62 homes.

Quality Measures

The quality performance of the participating nursing homes will be assessed based on the following measures:

1. Staffing Domain (30% of Quality Score): The staffing measures for the demonstration are:

   - 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 turnover rate.

   Because differences in resident acuity affect the staffing levels needed to care for residents, the measures based on staffing level will be case mix adjusted. At a minimum, the casemix adjustment will be based on a nursing home's average Resource Utilization Groups-III nursing index.

   CMS will collect payroll data from participants each quarter. These data will be used to calculate the nursing home staffing and turnover measures.

2. Appropriate Hospitalizations Domain (30% of Quality Score): There are separate measures for nursing home short stayers and long stayers, based on the hospitalization rates of potentially avoidable hospitalizations.

   Potentially avoidable hospitalizations will include hospitalizations for a set of conditions. The potentially avoidable hospitalization measures will be risk-adjusted, using covariates from Medicare claims and the Minimum data set (MDS.)

3. MDS Outcomes Domain (20% of Quality Score): A subset of outcome measures has been selected for the demonstration based on their validity, reliability, statistical performance, and policy considerations:

   Chronic Care Residents: We will use five of the quality measures (QMs) posted on Nursing Home Compare:

   - Percent of residents whose need for help with daily activities has increased;
   - Percent of residents whose ability to move in and around their room got worse;
   - Percent of high-risk residents who have pressure ulcers;
   - Percent of residents who have had a catheter left in their bladder; and

- Percent 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 (PAC) Residents: We will use three of the PAC quality measures that were validated in 2004:

- Percent of residents with improving level of Activities of Daily Living (ADL) functioning;
- Percent of residents who improve status on mid-loss ADL functioning; and
- Percent of residents experiencing failure to improve bladder incontinence.

When MDS 3.0 is implemented, CMS will review this domain and may revise the measures as appropriate.

4. Survey Deficiencies Domain (20% of Quality Score): The survey deficiency domain will be used in two ways:

   - Survey deficiencies serve as a screening measure. Any nursing home that, in the demonstration year, receives a citation for substandard quality of care or that has one or more citations for actual harm or higher will not be eligible to receive a performance payment. This screening criterion will ensure that homes with otherwise high performance scores will not receive a performance payment if they had serious quality of care issues identified by surveyors.

   - Survey deficiencies serve as part of homes' performance scores, based on the deficiencies that homes receive on their survey. Values will be assigned based on the scope and severity of deficiencies and the regulatory areas where deficiencies occur. Nursing homes will be ranked within each State according to their values.

   Note that performance scores will be determined on a state-by-state basis, reducing concerns about the variations in survey outcomes across States.

Total performance score: Each year, CMS will determine the number of points that each nursing home is assigned for each domain, and will sum the points across all domains to yield an overall score for each nursing home.

State Payment Pool Calculations

A payment pool will be estimated each year for each State. The demonstration will be budget neutral to Medicare for each State.

After the conclusion of each demonstration year, CMS will compare risk-adjusted Medicare Part A and B expenditures between the demonstration and comparison groups in each State. CMS will calculate the difference between the demonstration group's actual Medicare expenditures and the "target" expenditures (i.e., what we would expect Medicare expenditures for beneficiaries in demonstration homes to be in the absence of the demonstration). The target expenditures will be calculated using base year expenditures for the demonstration group and the rate of change in expenditures for the comparison group since the base year.

To determine each State's payment pool, a shared savings approach will be applied. First, the difference between actual and target expenditures must exceed 2.3 percent of Medicare Part A and B expenditures. This threshold avoids paying for small differences that could be due to chance. Second, savings above the threshold will be divided, with 80 percent going to the payment pool and 20 percent retained by the Medicare program. Third, the payment pools will not be larger than 5 percent of the target Medicare Part A and B expenditures. Any estimated savings above this cap will be retained by Medicare.

Performance Payments

The intent of the demonstration is to reward homes that provide overall high quality care rather than those that excel in individual areas. Nursing homes will be eligible for awards based on both attainment and improvement. Each year of the demonstration, CMS will determine which participants are eligible for performance payments based on the following:

- Homes with an overall performance score that is in the 80th percentile or higher in terms of performance level qualify for a performance payment. Homes in the 90^{th} percentile or higher would receive a performance payment that is 1.2 times the payment to those in the 80^{th} to 90^{th} percentile.

- Homes in the 80^{th} percentile or higher in terms of improvement qualify for a performance payment in recognition of their improved performance (with those in the 90^{th} percentile or higher receiving 1.2 times the payment as above), as long as their performance level was at least as high as the 40th percentile in the performance year. This required minimum level will ensure that homes do not receive performance payments for improvement if their overall level of performance is low.

- Performance payments will be based on the composite performance score rather than the scores on individual performance measures or categories of measures. Homes that qualify for a performance payment based on both performance level and improvement that are in different deciles (e.g., the 90^{th} percentile or higher for improvement and the 80^{th} percentile or higher for high scores) would receive payment for either performance or improvement but not both. They would receive the higher of the two performance payments for which they qualify (e.g., for improvement but not high score).

- Payments are based on the "size" of the nursing home (i.e., the number of resident days

for residents who are Medicare beneficiaries, including beneficiaries whose nursing home stay is not covered by Medicare).

- To assure that qualifying nursing homes contribute to reduced hospitalization rates (thus savings), a nursing home will not qualify for a performance payment unless it meets one of the following conditions. Either: (a) The nursing home's hospitalization rate in the demonstration year does not exceed its base year rate plus 20 percent; or (b) The nursing home's hospitalization rate in the demonstration year does not exceed the median hospitalization rate for the comparison group for that year in that State.

Evaluation

CMS will conduct an evaluation of this demonstration. Lessons learned from the evaluation will inform the design of a potential national nursing home value-based purchasing program.