Using Payment to Drive Quality Improvement in Medicare and Medicaid

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Solving problems, guiding decisions – worldwide
Overview of Presentation

• CMS Nursing Home Value-Based Purchasing Demonstration (NHVBP)

• States with financial incentive programs
  – Iowa
  – Kansas
  – Minnesota
  – Oklahoma

• States with non-financial incentive programs
NHVBP Background

- Institute of Medicine (IOM) recommends aligning 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
NHVB Design Considerations: MedPAC and JCAHO Recommendations

• Performance measures should be credible, valid, and reliable.
• System should reward both improvement and high quality, thus promoting improvement for providers with different levels of performance.
• Data collection should not be burdensome and should use data that are already collected where possible.
• Risk adjustment should be used where appropriate.
• Rewards should be great enough to drive desired behaviors and support consistently high quality care.
• A sliding scale of rewards should be established to allow for recognition of gradations in quality of care, including service delivery.
• Pay-for-performance programs should be budget neutral in the aggregate.
• Use a combination of financial and non-financial incentives.
• Give timely feedback to providers about their performance.
NHVBP Overview

• Expected to be implemented sometime in 2009, following state and nursing home selection

• Demonstration design
  – Anticipate 4-5 demonstration states with approximately 50 demonstration facilities in each state.
  – Participation will be voluntary—interested facilities may be assigned to either the demonstration group or a comparison group.
  – First year of demonstration a “formative stage” with refinements to the measures and to the design considered for year 2.
NHVBP Includes Four Basic Types of Performance Measures

• Staffing levels and stability
  – Strong evidence showing a relationship between staffing levels and quality of care (e.g., CMS Staffing Studies)
  – Case mix adjustment

• Potentially avoidable hospitalizations
  – Give nursing homes a direct incentive to reduce the rate of potentially avoidable hospitalization.
  – This is the most direct method by which nursing homes can control Medicare expenditures.
NHVBP Includes Four Basic Types of Performance Measures

• Outcomes from State inspection survey
  – On-site, independent observation of nursing home quality.
  – Nursing homes with certain types of severe deficiencies should be ineligible for an incentive payment.

• Quality measures (QMs) from federal Minimum Data Set (MDS)
  – Use of QMs consistent with IOM recommendation to link financial incentives to patient outcomes.
  – Subset of quality measures selected based on reliability, extent to which measure is under the facility’s control, statistical performance, and importance.
NHVBP: Staffing Performance Measures

• Staffing measures:
  – RN hours per resident day
  – Total nursing hours per resident day
  – Turnover percentage for nursing staff

• Staffing data to be collected using payroll data submitted by demonstration participants

• Case mix adjusted using RUG-III
NHVBP: Hospitalization Performance Measures

- Focus on hospitalizations for a set of potentially avoidable conditions
- Measured separately for short- and long-stay residents
  - Short-stay hospitalization rate: Hospitalization within 30 days of admission
  - Long-stay hospitalization rate: Rate per resident day
- Measures are risk-adjusted, using information derived from Medicare claims and the MDS.
NHVBP: Performance Measure Based on Survey Inspection Results

- 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
    - May also consider number of revisits required to correct deficiencies
  - Screening measure: Facilities with substandard quality of care deficiency are ineligible for an incentive payment.
NHVBP: MDS-Based Performance Measures

- Use a subset of the MDS quality measures that have been validated, focusing on those that are under the facility’s control, that have good statistical performance, and reflect important societal values.

- Long-stay measures
  - % 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 with pressure sores
  - % of residents who had a catheter inserted and left in their bladder
  - % of residents who were physically restrained

- Short-stay measures
  - % of residents with improved level of ADL functioning
  - % of residents who improve status on mid-loss ADL functioning
  - Failure to improve bladder incontinence
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)

- End of Life care
  - Whether the nursing home has a contract with at least one hospice agency
  - Percentage of residents with an advance care plan that includes certain specific elements

- Staff immunization rate
NHVBP Design Considerations: Scoring Rules and Linking Performance to Incentive Payments

• 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?

• Linking performance to incentive payments
  – What percentage of participants should receive incentive payments?
  – Balance between rewarding high performance and improvement over time.
NHVBP: Scoring Rules and Eligibility for Incentive Payments

• Weights for performance measures:
  – Staffing: 30 points
  – Survey deficiencies: 20 points
  – Resident outcomes: 20 points
  – Potentially avoidable hospitalizations: 30 points

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

• 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 (as long as their performance level is at least the 40th percentile).
  – Payment pool allocated equally between improvers and those with high performance.
  – Payments weighted based on facility size
Demonstration must be budget neutral.

Determine the size of the incentive pool in each state based on the Medicare program savings achieved by demonstration facilities.

- Similar to Physician Group Practice demonstration, except that savings calculation is made across all demonstration facilities in a state.
- Medicare program savings estimated by comparing the pre-post change in Medicare expenditures for demonstration and comparison facilities.
- If no Medicare program savings are achieved, no incentive payments are made to any facilities, regardless of performance.
Overview of State Pay-for-Performance Programs

• States with financial incentives:
  – Iowa (Accountability Measures Incentive Program, initiated in 2002)
  – Kansas (Nursing Facility Quality and Efficiency Outcome Incentive Factor program, initiated in 2005)
  – Minnesota (Performance Based Incentive Payments, initiated in 2006)
  – Oklahoma (Focus on Excellence Program, initiated in 2007)

• Several other states have non-financial incentive based programs.
# State Incentive Programs – Summary of Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Iowa</th>
<th>Kansas</th>
<th>Minnesota</th>
<th>Oklahoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing Hours</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Retention/ Turnover</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Deficiencies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupancy</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDS Quality</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other Quality Measures</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other Measures</td>
<td>Resident council resolution rate; Resident satisfaction; Administrative costs; Special dementia unit; Medicaid utilization</td>
<td>Operating Costs</td>
<td>Use of pool staff</td>
<td>Falls, catheterization; restraints; unplanned weight loss; pressure sores; antipsychotic medications</td>
</tr>
</tbody>
</table>
Iowa Accountability Measures Incentive Program: Performance Measures and Scoring Rules

- Performance measures (12 possible points)
  - Survey (3 points)
    - Deficiency free survey (2 points)
    - Substantial Compliance survey (1 point)
  - Staffing (3 points)
    - Nursing hours per resident day (2 points)
      - Based on relative distribution (1 point if between 50-75\textsuperscript{th} percentile, 2 points if above 75\textsuperscript{th} percentile)
      - Case mix adjusted using RUG-III system
    - High staff retention (above 72.3%)
  - Other (6 points)
    - High occupancy rate (above 95\%) (1 point)
    - High resident council resolution rate (above 60\%) (1 point)
    - High resident satisfaction scores (above 50\% percentile) (1 point)
    - Low Administrative costs (below 50\% percentile) (1 point)
    - Special Dementia Unit (1 point)
    - High Medicaid Utilization (above 50.41\%) (1 point)
### Iowa: Determining Size of Incentive Payment

<table>
<thead>
<tr>
<th>Total Points</th>
<th>Percentage Payment</th>
<th>Per Diem Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 2 points</td>
<td>No additional reimbursement</td>
<td>$0 per day</td>
</tr>
<tr>
<td>3 – 4 points</td>
<td>1% of the direct care and non-direct care medians</td>
<td>$.95 per day</td>
</tr>
<tr>
<td>5 – 6 points</td>
<td>2% of the direct care and non-direct care medians</td>
<td>$1.91 per day</td>
</tr>
<tr>
<td>7 or more points</td>
<td>3% of the direct care and non-direct care medians</td>
<td>$2.86 per day</td>
</tr>
</tbody>
</table>
Iowa: Program Assessment

- No formal evaluation, but there has been a small increase in deficiency free surveys; the impact on staffing levels and retention has not been examined.
- The program is fairly easy/inexpensive to administer
- The State reports general satisfaction by providers with the measures and the system
Kansas Nursing Facility Quality and Efficiency Outcome Incentive Factor

- Kansas pay-for-performance program is similar to that used in Iowa.

- In addition to its pay-for-performance program, the Kansas Promoting Excellent Alternatives in Kansas” (PEAK) Nursing Homes Initiative, which has two components:
  - Recognition for nursing homes pursuing progressive models of care
  - Education to nursing homes on instituting change: Kansas Department on Aging contracted with Kansas State University to produce educational materials and training modules
Kansas: Performance Measures and Scoring Rules

- Staffing (4 points)
  - Direct care staffing hours per resident day (2 points if above 120% of state median; 1 point if between 110% and 120%)
  - Staff turnover below state median (1 point)
  - Staff retention above state median (1 point)

- Survey deficiencies (2 points)
  - 1 point if deficiency-free
  - 1 point if no deficiencies > scope/severity “E” and not more than 5 total deficiencies

- Occupancy (2 points)
  - Total occupancy above 95% (1 point)
  - Medicaid occupancy above 65% (1 point)

- Operating costs below state median (1 point)
Kansas: Incentive Payments

- Thirty-eight percent of nursing homes in the State received a quality incentive payment.

<table>
<thead>
<tr>
<th>Total Incentive Points:</th>
<th>Incentive Factor Per Diem:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: 8-9</td>
<td>$3.00</td>
</tr>
<tr>
<td>Tier 2: 6-7</td>
<td>$2.00</td>
</tr>
<tr>
<td>Tier 3: 4-5</td>
<td>$1.00</td>
</tr>
</tbody>
</table>
Minnesota Value-Based Reimbursement Program

• The VBR system implemented by the State in October 2006 is based on performance in five domains:
  
  — Staffing (50 points) (Continuous scoring rules were used, with points distributed proportionately over a range of values.)
    • Staffing turnover (15 points)
    • Staff retention (25 points)
    • Use of pool staff (10 points)
  
  — MDS-based quality measures (40 points)
    • Scoring based on proportion of measures for which the facility was better than the national average
  
  — Survey measures (10 points)
    • 0 points if one or more deficiency at H level or higher
    • 5 points if facility had deficiencies at F or G level
    • 10 points if all deficiencies were below Level F

• Maximum quality add-on is 2.4 percent
Minnesota Performance Based Incentive Payments

- In addition to its value-based reimbursement program, the state has a Performance-Based Incentive Payments program that allows facilities to earn performance-based incentive Medical Assistance payments.

- Program allows for one-time rate adjustments of up to 5 percent of the operating payment to selected facilities who propose specific strategies to improve their performance.

- Facilities rated on 8 components, including:
  - How well the proposal addresses goals of program (Improved quality and efficiency and rebalancing of ltc system)
  - Whether the proposal addresses a priority issue
  - New and innovative concepts and strategies
  - Broad based applicability
  - Prospective/sustainable goals
  - Feasibility

- Incentive pool: Funding for FY2009 is $6.7 million
Minnesota Performance Based Incentive Payments: Examples of Funded Projects

- “The home is proposing to enhance the bathing experience by improving/updating four existing tub rooms to include towel warmers, CD players and a privacy screen.”

- “Nursing facility proposes to reduce resident pain and improve pain-related quality of life by utilizing the Brief Pain Inventory assessment tool and staff training on pain.”

- “The home is proposing to improve the clinical outcomes of congestive heart failure (CHF) residents. Included in the project is the purchase of an electronic charting system and a wheelchair scale.”

- “Nursing facility to install a wireless, soundless call system which will include integration of existing safety precautions and alert systems that signal emergencies, needs, and concerns.”

- “Nursing facility will implement an evidence-based diagnosis and treatment of osteoporosis for high risk post fracture patients in the rehab setting.”
Part of State’s Focus on Excellence program, which was initiated in 2007. The program has three main elements:

- Tiered reimbursement based on quality rating system
- Public reporting system with nursing facility quality ratings
- Evidence-based management data and tools for provider performance improvement

Participation is voluntary, but there are strong financial incentives to participate.

- 95% of facilities in the state are participating.
- No provider faces reimbursement decrease as a result of participating.
Oklahoma Focus on Excellence Program: Performance Measures

- Survey deficiencies
- Staffing: Nursing hours per resident day (CNA, LPN, RN), CNA turnover and retention, nurse turnover and retention
- Clinical measures
  - Falls, catherization, restraints, unplanned weight loss, pressure sores, anti-psychotic medications).
  - These are not derived from the MDS, but are reported by the facility using a web-based reporting tool.
- Other
  - Resident satisfaction
  - quality of life (from resident/family satisfaction survey)
  - employee satisfaction (from employee survey)
  - occupancy,
  - level of person-centered care,
  - Medicaid occupancy
  - Medicare utilization ratio
Oklahoma Focus on Excellence Program: Scoring Rules and Incentive Payments

• Scoring rules
  – Each measure is weighted equally. Scoring is based on whether the facility was at or above the median on the measure.
  – Facilities that receive a minimum number of points are eligible for an incentive payment, with the size of the incentive payment increasing with above-average performance on more measures.
  – State may also eventually consider improvement over time

• Incentive payments
  – 1% participation bonus for first year
  – Providers can earn incentive payments of 1% to 4% (up to $1.09 to $4.36 per patient day.
  – In the last quarter of 2007, above 50% of participating facilities qualified for an incentive payment
States with Non-Financial Incentives

- **North Carolina** (NC New Organizational Vision Award, initiated in 2007) uses a special licensure program for nursing homes that demonstrate a positive workplace culture to improve recruitment and retention.

- **Vermont** (Gold Star Program, initiated in 2005) recognizes facilities that institute evidence-based practices to improve recruitment and retention, particularly direct care staff.

- **Wisconsin** (Nursing Home Recognition for Performance Quality Initiative, initiated in 2007) uses a quality index scorecard based on a 100-point system. The scoring emphasizes staffing levels and stability, as well as stable leadership.
Conclusions

• Payment incentive programs in nursing homes are emerging, but not widespread
  – Medicare’s planned Nursing Home Value Based Purchasing Demonstration is expected to include 4-5 states
  – Only a few states have actually implemented or have specific plans for incorporating pay-for-performance into their nursing home Medicaid payment rates

• Little is known about the impact of these programs on quality.

• All existing programs include measures based on staffing levels, retention, and turnover, and survey deficiencies.

• There is no consensus about: other measures to include; how to link performance to incentive payments; or size of incentive payments.

• Financial incentive and non-financial incentive programs are often used together