Public Policy

Nursing Home Value-Based Purchasing: Here to Stay

By Charles Crecelius, MD, PhD, FACP, CMD

The Affordable Care Act has mandated that the Centers for Medicare & Medicaid Services inexorably move toward a pay-for-performance system. So far, the nursing home industry has been minimally impacted. Hospital-based, value-based purchasing has only begun to be felt by the nursing home industry, and predominantly in a regional manner. The same can be said for fledgling accountable care organizations. Physicians practicing in post-acute/long-term care will soon be affected by value-based performance (see “The Coming Value- and Quality-Based Payment Policies” in CARING FOR THE AGES 2013;14(10):9).

Via the ACA, CMS is now planning on initiating nursing home value-based purchasing (NHVBP) starting in 2018. This column will look at the operational details and data behind it and try to answer the question of whether this will result in better patient outcomes or whether it will be another acronym headache.

Payments Tied to Performance

Skilled nursing facility payments will be subject to NHVBP as a result of the 2014 Protecting Access to Medicare Act (PAMA) (Public Law No. 113-93). The Congressional Budget Office projects the program will save Medicare $2 billion over the next 10 years. Health and Human Services (HHS) will specify an SNF all-cause, all-condition readmission measure before Oct. 1, 2015, and then a risk-adjusted potentially preventable hospital readmission rate by Oct. 1, 2016. PAMA requires a public reporting of readmission rates for each SNF on CMS’ Nursing Home Compare website starting on Oct. 1, 2017. Based on the SNF readmission measure, HHS must establish a performance standard, along with proposed yearly levels of achievement and improvement for SNFs to achieve a preferred payment status. HHS will then develop a scoring methodology for SNFs to create a system that will rank SNFs.

The actual reimbursement differential based on hospitalization rates will start in 2018 and include an initial withholding of 2% of SNF (Medicare Part A) payments from the current prospective payment system. CMS will keep 30%-50% of this withholding to achieve overall savings, and the other 50%-70% will go to the higher performing facilities, depending on whether goals are achieved. It is anticipated that 40% of all SNFs will not get a full refund of the 2% initial payment.

Will Incentives Improve Care?

A major question in this proposed payment system is: will it work? And how will it affect nursing home behavior and services? CMS had commissioned a 3-year demonstration project to determine the effects of NHVBP in July 2009 to try to answer these questions. The study, “Evaluation of the Nursing Home Value-Based Purchasing Demonstration,” by L&M Policy Research and Harvard Medical School was released in August 2013 (Contract No. HHSM-500-2006-00091/ TO 7). The results were not overly impressive, but valuable lessons may have been learned.

Three states—New York, Wisconsin, and Arizona—were selected and qualified for the demonstration project. Each had somewhat unique circumstances. Generally, New York had primarily urban, independent, for-profit homes with almost no managed care experience. Wisconsin homes had a good amount of quality improvement experience and fewer Medicaid beds, and Arizona had more managed care and more chain homes. The states did not differ statistically in quality measures or hospitalization rates during the study. During the 3 years, the states were eligible for incentives under the model; only Wisconsin in 2 years and Arizona in 1 year received any such payments. Further analysis suggested that these payments occurred only because the base year had unusually high expenses, and that the savings seen most likely represented regression to the mean. In other words, incentive payments were probably a statistically anomaly. The report concluded that neither expense nor quality was improved in this demonstration project.

If They Build It, Will They Come?

If money talks, why didn’t the homes in the demonstration project do better? As is often true, we learn better from our mistakes than our successes, and the report on this demonstration proposed many plausible reasons for the outcomes. How CMS responds to these suggestions can have a major impact on whether patient care and expenses really improve under NHVBP. How facilities and practitioners meet the challenges of this new system will also substantially affect facilities’ fiscal success and the quality they provide.

That said, the complexity and extent of the reward for improving care need to be realistic. In the study, the first 2.3% of savings went to CMS and then the home could get 80% of what remained. Although using a 2.3% threshold may have made some statistical sense, as it was ascribed to yearly variation in payments, it can have a disheartening effect on reward for early improvements. The study had a substantial delay in getting data and reimbursement to the homes using a yearly reporting system. The administrator turnover at times was great, though in some cases, new personnel only discovered the home was participating in the project in the year they pleasantly received an unexpected bonus from CMS. More frequent payment adjustments could help facilities really understand how they are doing. In conjunction with timely performance reports, this could provide far greater incentive and ability to improve needed processes.

Facilities need to get real-time data to act on issues when they are present and not months to a year afterward. The study provided yearly reports, certainly not often enough to do necessary quality improvement projects to improve care and contain costs. This is also true for the demonstration report for OSCAR (Online Survey, Certification and Reporting) reports, which provide data that is 3-6 months old. Electronic health record (EHR) capabilities are far from being maximally utilized in PA/LTC, and physician EHRs, if present, do not interface well with the facility. Pharmacy EHR integrated interfaces are virtually nonexistent. Optimizing EHR systems has the potential to greatly improve quality improvement processes, but the capital investment needed is daunting.

Quality Assurance and Performance Improvement (QAPI) will need to be entrenched in facilities that want to succeed under NHVBP. Many homes will need help from various stakeholders, including AMDA, to learn how to jointly improve care and economies. The demonstration project noted many participants felt the experience was an “absolute missed opportunity,” as stakeholders such as the home associations were not invited to be involved in the project. CMS does offer substantial material on QAPI and has more recently been working with various stakeholders to jointly improve care. The demonstration project also noted CMS might consider requiring homes to participate in structured educational efforts to improve their QAPI knowledge before they are eligible for incentive payments. Continued joint efforts on how to navigate the NHVBP system will be critical to improve care and control costs.

Where’s the Practitioner in This?

The demonstration report made essentially no mention of the role of the medical director or practitioner in ensuring the success of NHVBP which is a major concern. There was passing commentary from participants, mainly administrators, regarding the perceived value of strong physician and nurse practitioner involvement, but no statistical efforts toward quantifying this were made. This has been a common theme in pay for performance-based systems. We must work jointly and collegially to improve care, and systems that tend to silo major stakeholders make true success difficult. Although there will be some differences in measures and outcomes, too often the entities involved in the PA/LTC arena lack common or integrated measures to strive for. Hospitalizations seem to be the only shared measure, which, although important, is far from an all-encompassing measure of jointly provided quality of care.

Undoubtedly, some physicians are hesitant to take ownership of quality measures. The survey process is not always fair, and it is difficult to fairly compare facilities with divergent populations. Without more sophisticated systems to measure true improvement, poor performing homes may never find competent physicians under a jointly shared performance system. Conversely, some facilities may be scared of owning the practitioners’ performance. However, until equitable means of risk-adjusted incentives that jointly reward facility and practitioner performance are derived, true quality cannot be optimized.

The NHVBP is legislatively here to stay, and CMS is doing its duty to ensure it is enacted on the timetable set by the ACA. However, it is not just up to CMS, but all of us, to make certain it truly improves patient care and is not just another acronym headache. More than ever, stakeholders must work together to ensure resident quality of care is the best it can be and that economics are pragmatic.

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