Quality-Based Nursing Home Reimbursement: Issues and Opportunities

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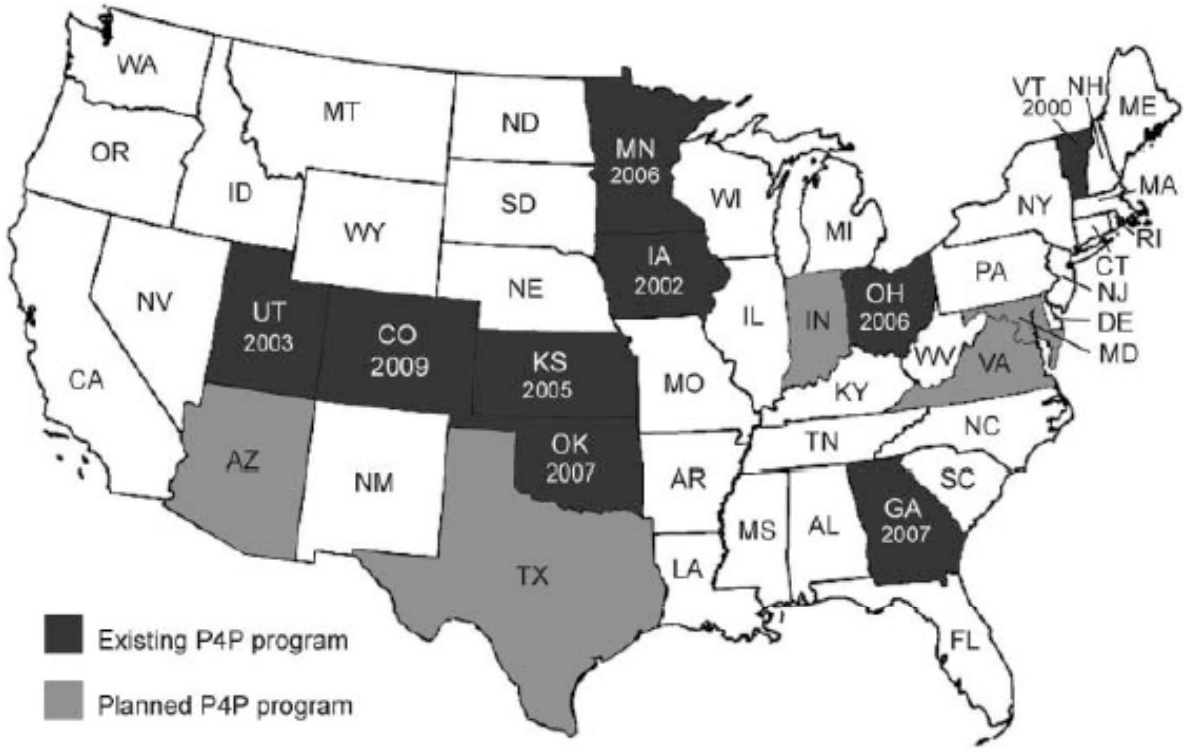
Outline

- Addressing issues in quality-based reimbursement
- Defining and measuring care quality
- Incorporating quality into the reimbursement system
- Building the capacity for quality improvement

Figure 1
States With Existing or Planned Nursing Home Pay-for-Performance (P4P) Programs in 2009. In States With Existing P4P Programs, the Year of Implementation Is Also Displayed



Werner, R. M., Tamara Konetzka, R., & Liang, K. (2009). State adoption of nursing home pay-for-performance. *Med Care Res Rev, 67*(3), 364-377.

Approaches to NH Quality

- Traditional Regulatory Model
  - Problem focus
  - Punitive
  - Adversarial
- Quality-Based Reimbursement
  - Emphasis on high quality, not just problem avoidance
  - Rewarding
  - Collaborative and supportive - engages providers in the quality process

Key Questions

- What is high quality care?
  - Quality is multidimensional – the nursing facility is both a care setting and living environment
  - Quality domains should represent the perspectives different stakeholders
- Can we measure quality effectively?
  - Meet scientific criteria – validity and reliability
  - Credible to stakeholders
  - Administratively feasible

Key Questions (cont.)

- What is the best way to structure financial incentives to promote quality?
  - Bonus or rate add-on tied to a quality score
  - Other quality-based rate adjustments
  - Capacity building programs – Minnesota PIPP
- Will these incentives work?
  - Providers must be capable of improving quality
  - There should be a sufficient business case or ROI
  - Avoid unintended or negative consequences

Guiding Principles – Quality Measures

- Comprehensive – contains process and outcome indicators, quality of care and quality of life
- Relevant – taps dimensions of care that are important to consumers and providers
- Credible – has strong research base
- Understandable – effectively presented to different audiences
- Actionable – informs consumer decision-making and provider quality improvement
- Administratively feasible – reasonable data collection cost, integrated with care delivery
- Transparent – methods are well described, in the public domain, and open to scrutiny by stakeholders and the research community

Quality Measurement and Application

- Quality measurement and application should be:
  - Well connected
  - Mutually reinforcing
- Application of quality information:
  - Gives providers a stake in data collection
  - Can also introduce bias
- Reporting systems should encourage provider and other stakeholder feedback:
  - Serve as an accuracy check
  - Refines and improves reporting

Rating of Quality Domains by Minnesota Nursing Home Report Card Users (N=108,000)

Quality Dimension	% Giving it Top Priority
Quality of Life/Resident Satisfaction	84%
State NH Survey Results	61%
NH MDS Quality Indicators	59%
Staffing Level (HPRD)	38%
Staff Retention	16%
Use of Pool Staff	6%

Quality Measures

Dimension	Measure	Typical Data Source
Staffing	Nurse and other direct care staffing levels (hours per resident day); staff retention or turnover rate; use of pool or contract staff	Cost Report
	Staff satisfaction with work environment, management, relations with other staff, teamwork, training opportunities, and organizational culture.	Staff satisfaction survey

Quality Measures (Cont.)

Dimension	Measure	Typical Data Source
Nursing Home Inspection	Scope and severity of deficiencies in clinical care, resident quality of life, resident rights, dietary services, and physical environment, or other services.	Nursing home inspection data
Clinical Quality Indicators	Nursing home quality indicators (QI/QMs) such as pressure sores, physical or chemical restraints; decline or improvement in ADLs, etc.	Minimum Data Set (MDS)

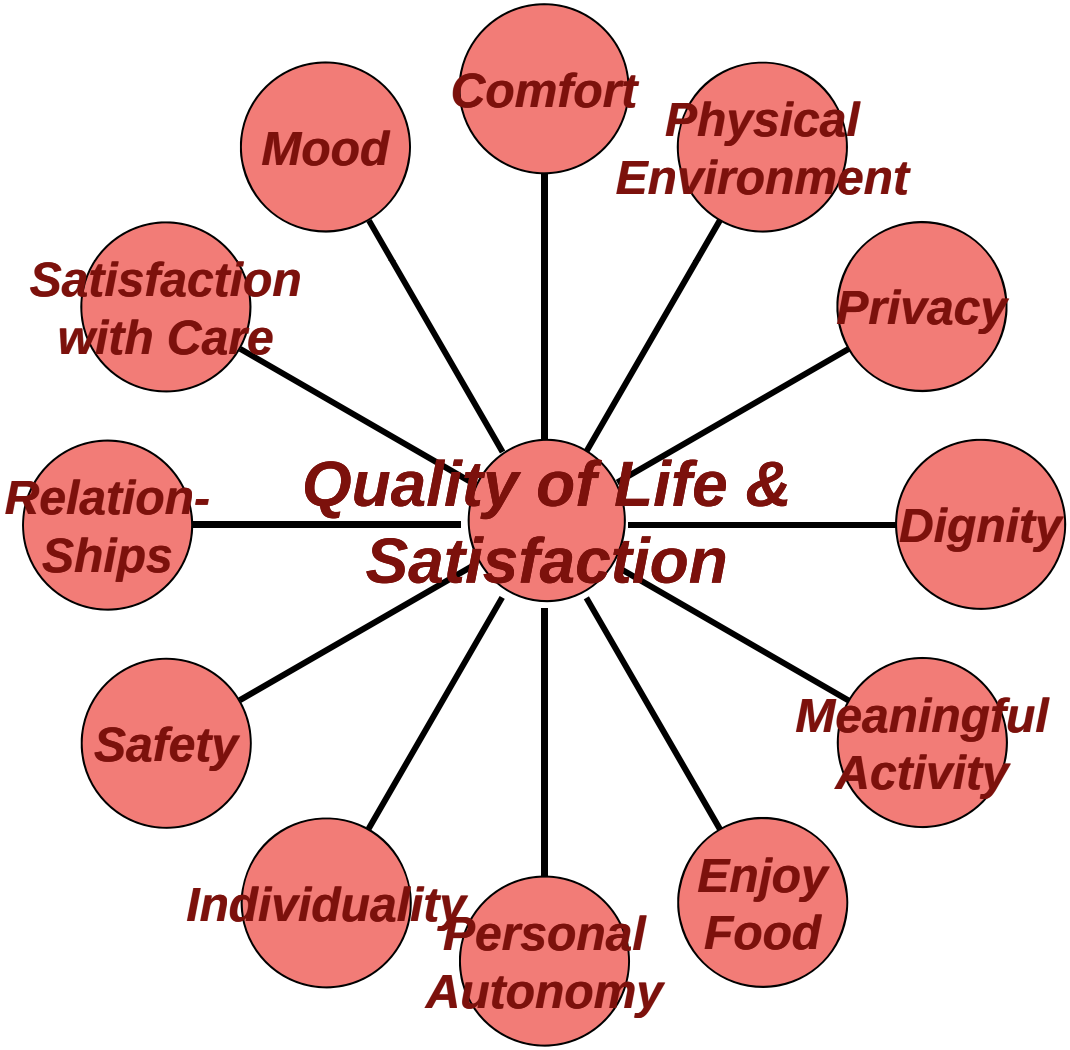
Quality Measures (Cont.)

Dimension	Measure	Typical Data Source
Resident Quality of Life	Resident self-perceived quality of life	Quality of life survey
Consumer Satisfaction	Resident or family satisfaction with nursing home services, environment, staff, and quality of life.	Resident or Family satisfaction survey

Example: Minnesota Quality of Life & Resident Satisfaction Survey

- Annual survey carried out by professional survey organization
- Face-to-face interviews with 14,000+ NH residents
- QoL and other satisfaction questions adapted from established instruments
- Risk adjusters -- Resident gender, ADL, age, cognitive status & LOS
- All cognitive levels participate except for the most severely cognitively impaired
- 85% response rate

Minnesota Resident Quality of Life Domains



Quality Measures (Cont.)

Dimension	Measure	Typical Data Source
Care Transitions	Community Discharge Rate – Proportion of residents returning to the community within 90 days of nursing facility admission (case-mix adjusted) Hospitalization/Re-Hospitalization Rate – Rate of admissions from nursing home to hospital (case-mix adjusted).	Minimum Data Set (MDS)
Resident-Centered Care	Enhanced Dining, Flexible and Enhanced Bathing, Flexible Daily Schedule, End of Life Program, Private Resident Rooms, Neighborhood/ Households, and Consistent Staff Assignment	Specialized surveys

Incentives for Better Quality

- Paying facilities directly for better care through a bonus or rate add-on tied to a quality score
- Building facility capacity for quality improvement Minnesota's Performance Incentive Payment
- Influencing consumer demand through public reporting – e.g., Medicare's NH Compare

Quality Bonus

- Bonus payment is most common approach
- Set aside a pool of Medicaid funds – new appropriations or carved out of current budget
- Calculate a facility quality score – weighted average of scores in individual domains
- Pay annual bonuses to facilities
  - Fixed payment to high performing facilities (top 10%)
  - Varying payment proportional to facility quality score

Table 3
Summary of the Size of Financial Incentives Used in State Nursing Home Pay-for-Performance (P4P) Programs

	Maximum Per Diem Add-On	Average Per Diem Rate[a]	Total Paid in P4P Bonuses (in millions)	P4P Bonuses as Percentage of Nursing Home Budget
Colorado	$4.00	$143.75	—[b]	—[b]
Georgia	1.0%[c]	$119.51	$5.0	0.4
Iowa	$3.68	$102.56	$6.7	1.4
Kansas	$3.00	$101.81	$2.4	0.7
Minnesota	2.4%[c]	$137.01	$12.0	1.4
Ohio[d]	$6.16	$157.00	$18.4	0.6
Oklahoma	$5.45	$96.20	$12.7	1.8
Utah	$0.60	$105.55	$1.0	0.7
Vermont	—[e]	$147.24	$0.1	0.1

a. Based on 2004 estimates in Grabowski, Zhanlian, and Mor (2008).
b. In Colorado, where the P4P program was initiated in 2009, bonuses have not yet been paid out.
c. Bonuses are a percentage of the facility's per diem rather than an absolute amount.
d. Receipt of bonus payment is contingent on having costs that are below established price points.
e. Bonuses are not based on per diem add-ons. Each nursing home that qualifies for a bonus payment receives $25,000.

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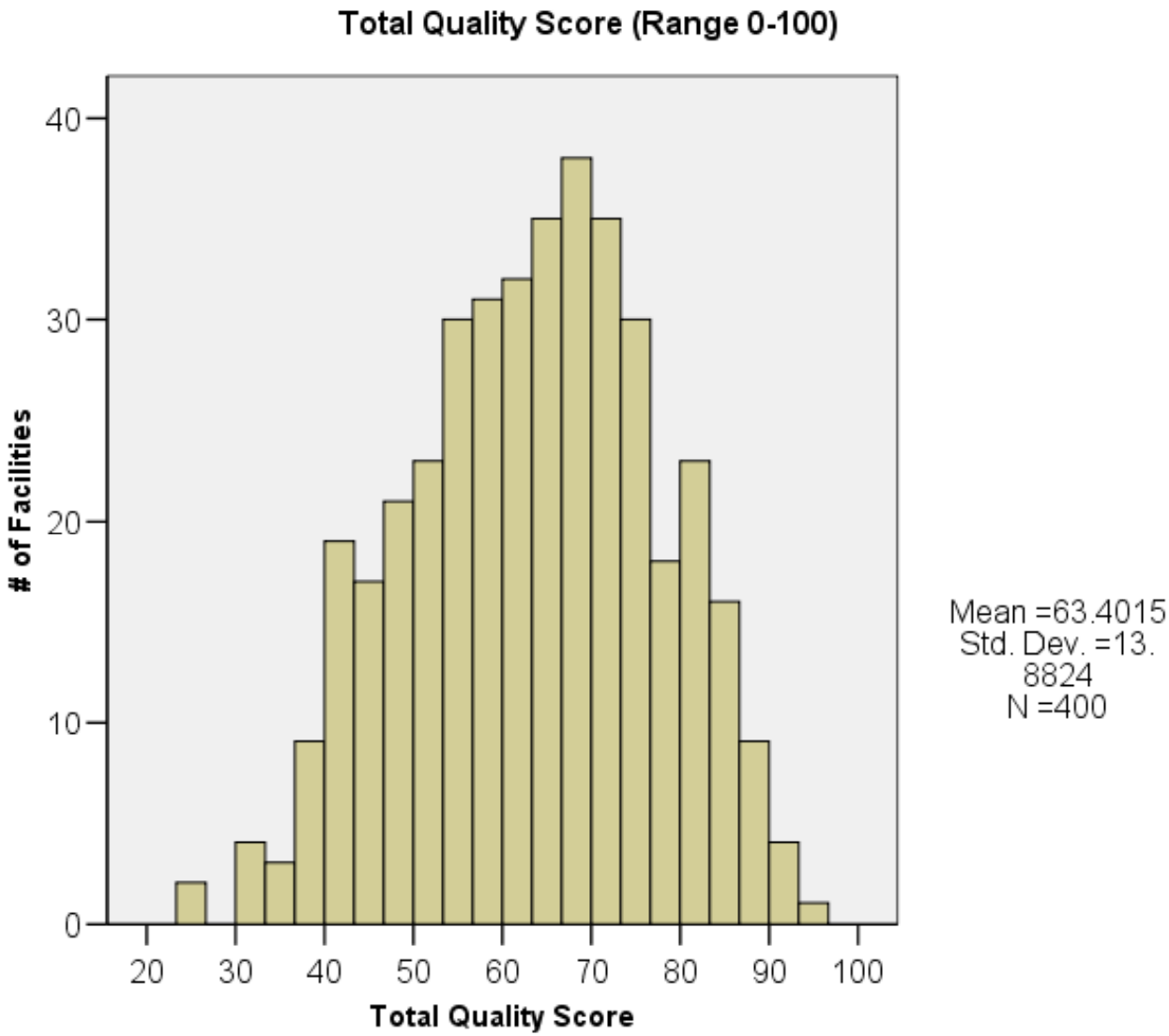
Bonus System Design

- All facilities should participate in bonus system
- Set stable and predictable quality standards – avoid moving targets, i.e., percentile systems
- Reward improvement across continuum of performance -- avoid the rich getting richer and the poor getting poorer

Minnesota Quality Score

Measure	Max Points
Staffing level (HPRD)	10
Staff retention	10
Use of pool staff	5
QIs	25
Resident Quality of Life	35
Survey deficiencies	15
Total	**100**


Total Quality Score (Range 0-100)
# of Facilities
40
30
20
10
0
20
30
40
50
60
70
80
90
100
Total Quality Score
Mean =63.4015
Std. Dev. =13.
8824
N =400


Bonus (Per Diem)
5.00
4.00
3.00
2.00
1.00
0.00
$3.00
Full Bonus
Proportional
No Bonus
Poor Quality
30
60
90
Quality Points
Best Quality

Facility Capacity Building

- Specialized quality reporting systems – e.g., My InnerView
- Quality improvement collaboratives – e.g., Building Excellence in NHs
- Technical assistance directed at the poorest performing facilities
- Stimulating broad-based quality improvement, e.g., Minnesota's PIPP Program.

Minnesota PIPP Program

- Objectives
  - Foster innovation and risk taking
  - Build quality improvement capacity
- Facilities design a project to improve quality and effectiveness of care
- Facilities receive up to a 5% rate increase IF they:
  - Implement the project effectively
  - Achieve measurable quality outcomes

Cooke, V., Arling, G., Lewis, T., Abrahamson, K. A., Mueller, C., & Edstrom, L. (2010). Minnesota's Nursing Facility Performance-Based Incentive Payment Program: an innovative model for promoting care quality. *Gerontologist, 50*(4), 556-563.

MN PIPP Program (Cont.)

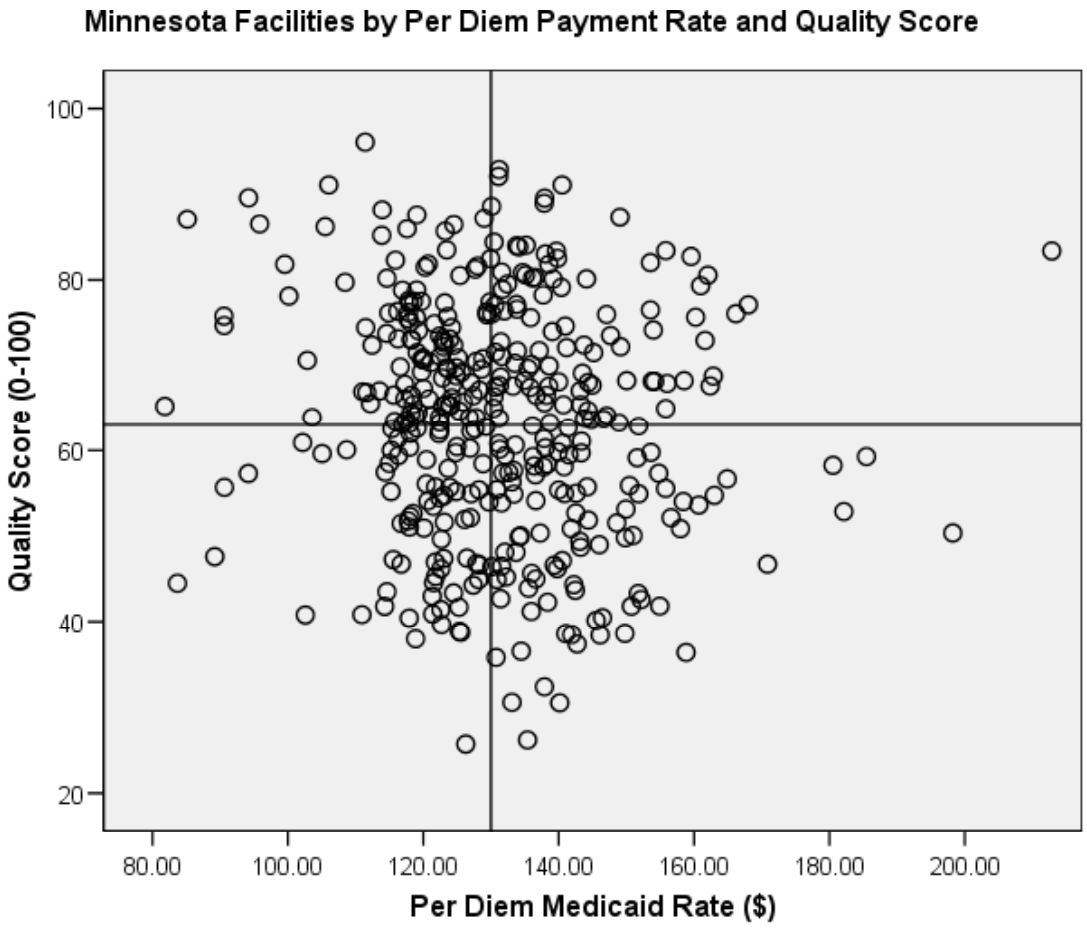
- Funding $18 Million/Year ($5 Million State)
- 175 project proposals
- 60 projects (180 facilities) funded 2007-2010
- Project Examples:

Culture change
QoL for dementia residents
Pressure ulcer prevention
Exercise
Wireless call systems
Employee retention
Pain management
NH Transitions

What was PIPP's impact on your facility? (2010 Survey)

Area of Impact	Very High Impact	Moderate Impact	Low/No Impact
Improving quality	53%	36%	10%
Stimulating new ideas	46%	43%	11%
More collaboration with other facilities	43%	31%	26%
Encouraging leadership and staff to be bold and take risks	41%	43%	16%
Changing organizational culture	37%	38%	25%
Staff involvement in quality improvement	34%	50%	16%
Better quality measurement tools	34%	47%	19%
Boosting staff morale	24%	43%	33%

The Challenge



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