Value-Based Purchasing

Rachel Manchester, BSN, MBA, MHA
Providence Health and Community Care
February 25, 2019

Value-Based Purchasing for Home Health

- Medicare was/is concerned the current design of the home health benefit does not provide the necessary incentives to provide high quality, patient focused care
- The Affordable Care Act of 2010 required a VBP program for payments under the Medicare program for home health agencies. Medicare began testing the VBP model for home health in 9 pilot states on January 1, 2016 using 2015 as the baseline year

Value-Based Purchasing for Home Health (cont.)

- CMS views implementation of VBP as an important step in revamping how Medicare pays for health care services – moving the program toward better value, outcomes and patient-focused care instead of VOLUME of services provided
- “First, we expect that tying quality to payment through a system of value-based purchasing will improve the beneficiaries’ experience and outcomes.”
  (Federal Register, 2016)
Program Goals

- VBP programs aim to hold providers accountable for quality care, effective, efficient care processes and address the variation in quality across care settings. The goals are:
  - Better Quality Care with greater efficiency
  - Study quality and efficiency measures for appropriateness in the home
  - Enhance the current public reporting process

Program Goals (cont.)

- VBP programs help ensure Medicare patients have access to timely, safe and effective home health services

  “In turn, we expect payment adjustments that both reward improved quality and penalize poor performance will incentivize quality improvement and encourage efficiency, leading to a more sustainable payment system.”
  (Federal Register, 2016)

Ground Rules

- Value-based incentive payments would be made in a fiscal year to home health agencies if they met defined performance standards. A payment reduction or increase to current Medicare payments depending on quality performance would be applied annually beginning at 3% and increasing to 8% in later years
- CMS seeks to continuously promote improvement in quality, efficiency and outcomes for Medicare beneficiaries
- VBP programs will align with department of health and CMS to improve coordination of care
Providers are expected to make necessary investments to redesign care to improve quality and efficiency of care delivered as a result of the incentive program. (Examples include new software, fall prevention initiatives, telemonitoring, nurse reviewers)

As new value-based payment mechanisms evolve, it's expected that payments will be diverted to agencies showing the highest qualitative measurements from those exhibiting lower quality.

Payment adjustments will be increased incrementally over the course of the HHVBP Model in the following manner:

<table>
<thead>
<tr>
<th>VBP year</th>
<th>% Payment Affected</th>
<th>Payment Recognized</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+/- 3%</td>
<td>2018</td>
</tr>
<tr>
<td>2017</td>
<td>+/- 5%</td>
<td>2019</td>
</tr>
<tr>
<td>2018</td>
<td>+/- 6%</td>
<td>2020</td>
</tr>
<tr>
<td>2019</td>
<td>+/- 7%</td>
<td>2021</td>
</tr>
<tr>
<td>2020</td>
<td>+/- 8%</td>
<td>2022</td>
</tr>
</tbody>
</table>

The distribution of payment adjustments will be based on quality performance, as measured by both achievement and improvement, across a set of quality measures rigorously constructed to minimize burden as much as possible and improve care.

Competing HHAs that demonstrate they can deliver higher quality of care in comparison to their peers (as defined by the volume of services delivered within the selected state), or their own past performance, could have their payment for each episode of care adjusted higher than the amount that otherwise would be paid under section 1895 of the Act.

Payments...
Payments ... (cont.)

- Competing HHAs that do not perform as well as other competing HHAs of the same size in the same state might have their payments reduced and those competing HHAs that perform similarly to others of similar size in the same state might have no payment adjustment made.

VBP Measures (20 Total)

Many measures come straight off of the OASIS ...

6 process, 10 outcome, 5 HHCAHPS and 3 New Measures to include:

- Influenza Vaccination Coverage for Home Health Care Personnel
- Herpes Zoster (Shingles) Vaccination
- Advanced Care Plan

The final three are reported by HHAs (home health agencies) through a Web Portal.

What are the Reportable Measures?

VBP Performance Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccination Coverage for Home Health Care Personnel</td>
<td>Outcome</td>
<td>Medicare Data</td>
</tr>
<tr>
<td>Herpes Zoster (Shingles) Vaccination</td>
<td>Outcome</td>
<td>Medicare Data</td>
</tr>
<tr>
<td>Advanced Care Plan</td>
<td>Outcome</td>
<td>Medicare Data</td>
</tr>
</tbody>
</table>

Note: Each measure has specific requirements and criteria for reporting.
There are a cluster from HHCAHPS data:
- Care of patients
- Communication between providers and patients
- Specific care issues
- Overall rating of home health care
- Willingness to recommend the agency

Finally, there are two that are from CMS Claims Data:
- Acute care hospitalization (re-hospitalizations within 30 days of start of HH care)
- Emergency department use without hospitalization

How We Reacted ...
- Implemented a quality review team to standardize OASIS assessments
- Where we couldn't hire positions we contracted with Blacktree
- Reviewed every OASIS time point
- Required all supervisors to get OASIS certified
- Conducted LYNC calls for staff education
- Saved time by using technology
- Used a real-life scenario
- Provided direct OASIS Answers responses
- Recorded the series for replay based on clinical findings
How We Reacted (cont.)

- Began to fully utilize SHP (Strategic Healthcare Partners) for data scrubbing down to the clinician level
- Helped identify clinicians who were struggling with the OASIS
- Began risk-stratifying patients for re-hospitalization risk at intake
  - Partnered with local hospitals and our EMR for standardized definitions
  - Implemented practice techniques based on high and medium risk
    - Front loading visits
    - Ensuring start of care done in 24 hours
    - Ensured an MD Follow up appointment in first seven days post discharge
  - Case conferences held for those patients who readmitted to determine root cause

First Year Findings

67 agencies were interviewed and here are some key findings:

- Behavior changes were evident in OASIS-Based measures
- Overall, agencies in the VBP states showed TPS (total performance score) improvements
- There were mixed results on reducing care variability as it related to spending and utilization
- There has been no evidence VBP has impacted the patient experience measures
- Mixed findings on the effects of the OASIS outcome measures

Source: HHVBP First Annual Report

Bottom 4 Areas Showed Improvements

Source: HHVBP First Annual Report
Year 1 -
Payment Model

Source: HHVBP First Annual Report

Year 1 -
Scores

Source: HHVBP First Annual Report

HCAHPS Improvement

Source: HHVBP First Annual Report
Year 1 - Financial Impact

At the 75%, the financial impact for year 1 was a 0.3% increase for our agencies.

Year 2 – 2017
TPS Scores
Performance

Source: CMS Final TPS Adjustment Report PY2

Year 2 – 2017
Adjusted Payment Percentages

Source: CMS Final TPS Adjustment Report PY2
At the 75%, the financial impact for year 2 was a 0.5% increase for our agencies.

Source: CMS Final TPS Adjustment Report PY2

There is no correlation between star ratings and TPS scores.

Source: CMS Final TPS Adjustment Report PY2

- The collection of quality data affects payments 2 years later — for example, quality data collected during 2017 will affect 2019 payments. This makes it difficult to budget.
- Medicare Advantage plan case managers may restrict or deny an agency’s treatment recommendations for a patient which will affect the outcomes for those patients.
- HHA will be punished for hospitalizations beyond their control and encourage agencies to cherry pick patients to improve scores.
- The HHCAHPS patient experience survey is too lengthy for elderly clients and are graded on a subjective survey that may or may not reflect the HHA’s care (as the senior could be confused about which provider the survey is for).
- The assumption is HHA operating at “average” should not be rewarded financially.
Some Fears and Concerns (cont.)

- Incentives funded would come from money saved from other HHA performing poorly instead of a different Medicare “pool”
- Reductions to Medicare home health agencies payments are estimated to be $37.9 billion between 2011 and 2019
- Is it fair to include certificate of need states as well as non-certificate of need states? Is this apples to apples

Some Fears and Concerns (cont.)

- The reductions are enormous – which could put home health agencies out of business
- Providence operates lower than national average for our overall case mix rates; how are they going to determine our threshold
- We need to see how they will determine threshold and benchmarks for payment reductions and incentives specifically as Washington on average is lower than the nation in some of the outcome measures and there is substantial variation on home health agencies – for profit is just one example

The VBP Model Continues to Change

- Other measures under consideration but not yet finalized ...
  - Timely initiation of care
  - Pressure ulcer prevention and care
  - Multi-factor fall risk assessment for all ambulatory patients
  - Depression assessment conducted
  - Adverse event for improper medication administration and/or side effects
2019 Changes

- Two OASIS based measures were removed (Influenza Immunization received and Pneumococcal vaccine received)
- Replaced three OASIS measures (improvement in bathing, improvement in bed transferring and improvement in ambulation/locomotion) with two composite measures Total Change in Self care, Total change in Mobility to align with OASIS D
- Change the weighting of existing measures

<table>
<thead>
<tr>
<th>VBP Metric</th>
<th>Current %</th>
<th>2019%</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS</td>
<td>31.25</td>
<td>30%</td>
<td>-1.25%</td>
</tr>
<tr>
<td>OASIS</td>
<td>56.25%</td>
<td>35%</td>
<td>-21.25%</td>
</tr>
<tr>
<td>Claims</td>
<td>12.50%</td>
<td>35%</td>
<td>22.50%</td>
</tr>
</tbody>
</table>

Source: Federal Register pgs. 32506/32507

2019 Expectations

Lessons Learned – Your Homework

- Understand the disconnect between CMS star ratings and TPS scores
- Pour resources into your revenue document
- Continue to focus on patient satisfaction because it is the right thing to do, not because you are going to see an increase in your ratings
- Communicate early and often with caregivers as culture change takes a long time
- Partner with your hospitals and other long term care providers to reduce care transition gaps
References

- US Department of Health and Human Services Report to Congress: Plan to implement a Medicare Home Health Agency Value-Based Purchasing Program. Retrieved 8.5.15 from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF

Skilled Nursing Facility: Value Based Purchasing

Lisa Harrold
Director, Rehabilitation and Skilled Nursing Services
Kaweah Delta Health Care District

The Measure

- 30-day all cause readmissions
  - Unplanned
  - Within 30 days of discharge from prior proximal acute care, critical access or psychiatric hospital stay
  - Risk adjusted for clinical characteristics and comorbidities
  - Medicare Fee-for-Service patients
Scoring

• Baseline period calendar year 2015
• Performance period calendar year 2017
• **Achievement Score**
  ✓ Achievement threshold = 25th percentile of national SNF performance. Rate worse than achievement threshold earns 0 points
  ✓ Benchmark = mean of the top decile of national SNF performance. Rate better than or equal to benchmark earns 100 points
  ✓ 1-99 points for performance between these two

Scoring (cont.)

• **Improvement Score** (from baseline to performance period)
  ✓ 90 points if better than or equal to benchmark
  ✓ 0 points if worse than SNF performance during baseline period
  ✓ 1-89 points for performance between these two
• **Performance Score** = the higher of a SNF’s achievement score and improvement score, basis for payment adjustments

Financial Impact

• Beginning Oct. 1, 2018
• 2% of each SNF’s Medicare payments withheld to fund incentive payments
• Not budget neutral – incentive payments total 60% of amount withheld. Estimated that 73% of SNF’s were penalized, 27% received bonuses.
• Bottom 40% of SNF’s will have reduced reimbursement. About 20% will receive the maximum penalty of 2%.
• Maximum bonus in fiscal year 2019 of 1.6%. About 3% of SNF’s will receive this bonus.
• Public ranking of each SNF’s performance: https://data.medicare.gov/Nursing-Home-Compare/SNF-VBP-Facility-Level-Dataset/284v-j9fz/data
What's Next

- Possible future alignment between quality reporting readmission measure and value based purchasing, with eventual goal of transitioning to potentially preventable readmissions, rather than all cause

Resources

- CMS webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
- National Nursing Home Quality Improvement Campaign www.nhQualityCampaign.org
Recommendations and Considerations

- Monitor results – get your real time data, know your trends and engage staff in addressing potentially avoidable readmissions.
- Educate and engage leadership, quality experts in your system to garner support for data collection and quality infrastructure.
- Never rest. Our initial success brought the following feedback from my boss: “Great work Team! Kudos to all! The key now is to maintain this position … is there any way to see how we are doing currently and is there anything we should do to hardwire any best practices to insure our position?” Good advice – everyone is working to improve, and the bar will continue to get higher.

Questions?

Raise your hand or submit questions at www.menti.com and enter code 36 75 60

Thank you

Rachel Manchester, BSN, MBA, MHA
Chief Nurse/Director of Clinical Quality of Home Health
Providence Health and Community Care
(425) 525-5234 x55231
Rachel.Manchester@providence.org

Lisa Harrold
Director, Rehabilitation and Skilled Nursing Services
Kaweah Delta Health Care District
LSchultz@kdhcd.org