

Value-Based Payment in Nursing Facilities: Options and Lessons for States and Managed Care Plans

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IN BRIEF: To improve the value of care provided in nursing facilities, payers are experimenting with value-based payment (VBP) approaches that link financial rewards to measures of quality. Drawing on findings from interviews with state officials and plan representatives, this brief describes the VBP approaches that select states and managed care plans currently use, presents perceived effects of VBP, and shares lessons on the design and administration of VBP programs. States interested in VBP may look to the examples in the brief to design their own VBP programs or encourage plans to do so.

States and plans that blend Medicare and Medicaid funding may find VBP especially attractive for improving nursing facility care for dually eligible beneficiaries who may move between skilled/rehabilitation and custodial stays. Though this brief found few examples of VBP approaches that fully integrate incentives across payers, states or plans that wish to develop such initiatives can draw from the lessons in this brief by measuring facilities on services and outcomes that require coordinated medical and custodial care, or by using alternative payment strategies that allow providers to share in additional risk and rewards.

Introduction

Over the past decade, multiple studies have raised concerns about the quality of care in nursing homes.¹⁻⁵ At the same time, national spending on nursing facility care has grown at a rapid pace, increasing from \$111.4 billion in 2005 to \$152.6 billion in 2015. In 2015, 55 percent (\$84.7 billion) of the cost of nursing facility care was paid for by Medicaid (32 percent) and Medicare (23 percent),⁶ either through fee-for-service (FFS) or managed care (e.g., Medicaid managed care plans, Medicare Advantage plans, or integrated plans, such as Medicare-Medicaid Plans [MMPs] under the Centers for Medicare & Medicaid Services [CMS] Medicare-Medicaid Financial Alignment Initiative capitated model demonstrations).

Despite the large share of nursing facility revenue that comes from Medicaid and Medicare, policymakers have long recognized the disconnect between public payments and quality of care. Traditional FFS reimbursement methods used under both programs are based to a large extent on costs and resource use reported by providers. These payment approaches provide strong incentives for increasing the number of patients served but weak incentives to improve quality. For Medicare-Medicaid enrollees, also known as dually eligible beneficiaries, dividing coverage between Medicare (for hospital and short-term skilled nursing facility [SNF] care) and Medicaid (for long-term nursing facility care) creates an additional incentive to shift costs from one payer to the other, resulting in gaps in care that threaten care quality, patient safety, and quality of life.⁷

In an effort to improve the value of care they purchase, CMS, states, and their contracted managed care plans are experimenting with value-based payment (VBP) approaches that reward providers with incentive payments based on the quality of care they provide.⁸ Such approaches may drive care improvement in nursing facilities and redistribute payments from low-quality to high-quality providers.⁹ Nearly all VBP nursing facility programs that the Integrated Care Resource Center (ICRC) reviewed as background for this brief operate as adjuncts to direct FFS reimbursement by Medicare and state Medicaid agencies. As more states contract with managed care plans to deliver integrated Medicare and Medicaid for nursing facility residents who are eligible for both programs, they can apply lessons from existing programs by working with their managed care plans to

incorporate VBP approaches. Integrated models include: (1) the Medicare-Medicaid Financial Alignment Initiative capitated model demonstrations, in which MMPs are responsible for all covered Medicare and Medicaid services including nursing facility care; and (2) aligned Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid managed long-term services and supports (MLTSS) plans that also cover both Medicare and Medicaid nursing facility and other services.

Between December 2016 and February 2017, ICRC interviewed officials from six states (Arizona, Indiana, Minnesota, Ohio, Tennessee, and Texas) that currently use VBP as an approach to improve quality of care in nursing facilities.¹⁰ In addition, ICRC interviewed representatives from five national and regional managed care plans – some, but not all, of which operated in the featured states. States and plans described key features of their programs, perceived effects of the programs, and lessons learned.

Drawing from interviews with these state officials and managed care plan representatives, this brief describes VBP approaches currently used in select states and managed care plans (Exhibit 1), including the quality and performance measures they use (Appendix 1), benchmarks or targets for those measures, and incentives that reward facilities (Appendix 2). It also describes approaches to designing, administering, and evaluating state programs. Finally, the brief presents additional mechanisms that can support and reinforce VBP, such as directing enrollees to preferred facilities, promoting innovative models of care, and sharing quality measures with facilities, even if they are not used for payment. (Appendix 3). These findings, along with the lessons that are discussed throughout the brief, may be useful for states and Medicaid managed care plans that are considering implementing VBP programs for nursing facilities. States pursuing integrated care programs for Medicare-Medicaid enrollees through contracts with D-SNPs and MMPs may find the brief's examples particularly useful, as D-SNP and MMP contracts offer the opportunity to combine Medicaid and Medicare payments to create incentives that recognize services covered by either payer.

Nursing Facility Payment Strategies

Reimbursement for Covered Services

Medicaid and Medicare payments are intended to reimburse facilities for the costs for providing care and, therefore, have the potential to influence quality. For Medicare-Medicaid enrollees who receive short-term SNF care paid by Medicare and long-term custodial nursing facility care paid by Medicaid, two different reimbursement methodologies apply:

- **Medicare** pays SNFs prospectively using a pre-determined, all-inclusive daily rate. Daily payments to SNFs are expected to cover all operating and capital costs that a facility would incur in providing most services, including room and board,¹¹ nursing services, therapies, radiology, laboratory, transportation, and prescription drugs. Payments are adjusted by case-mix to reflect variation in the intensity of services that residents with different care needs require. CMS updates SNF payments annually to reflect the national average costs of goods and services purchased by SNFs.¹² Medicare Advantage managed care plans that cover SNF services – including D-SNPs and Institutional SNPs – tend to mimic the underlying Medicare FFS reimbursement systems in their base payments to nursing facilities, though some have begun to experiment with bundled payments that include additional services associated with SNF care or other more sophisticated payment approaches.
- **Medicaid** allows states broad flexibility to structure reimbursement for nursing facilities. As of October 2014, a majority of state Medicaid programs paid facilities a daily rate established through cost-based models, but many others used price-based models, or a combination of both. Cost-based rates are established based on each nursing facility's reported costs, with each facility paid retrospectively based on its actual per-day costs up to a predetermined ceiling. Price-based rates prospectively pay providers a specified amount per day for similar services, with potential adjustments

Exhibit 1: Overview of State Nursing Facility (NF) Value-Based Payment Initiatives

State and Program Name	Year Started	Delivery System	Provider Participation	Program Objectives
Arizona: Value-Based Purchasing (VBP) Initiative	2013	Managed care	Voluntary	To encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through shared savings payment arrangements. ^a
Arizona: Value based payment differential	2017	Managed care	Voluntary	To distinguish providers committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. ^b
Indiana: VBP Initiative	2005	Fee-for-service	Mandatory	To incentivize NFs to improve quality and increase utilization of home- and community-based services (HCBS). ^c
Minnesota: Integrated Care System Partnership (ICSP)	2013	Managed care	Mandatory	To (1) improve quality of care for seniors and individuals with disabilities; (2) tie payment of services to financial performance and quality measures; and (3) improve care coordination. ^d
Minnesota: Performance-based Incentive Payment Program (PIPP)	2006	Fee-for-service	Voluntary	To (1) provide more efficient, higher quality care within the long-term care community; (2) encourage NFs to experiment and innovate; (3) equip facilities with organizational tools and expertise to improve their quality of care; (4) motivate facilities to invest in better care; and (5) share successful PIPP strategies throughout the nursing home industry. ^e
Minnesota: Quality Incentive Payment Program (QIIP)	2013	Fee-for-service	Voluntary	To recognize quality improvement efforts, and to ensure that all Medicaid-certified NFs in the state have the opportunity to receive financial rewards for improving their quality of care or quality of life. ^f
Minnesota: Value-Based Reimbursement (VBR)	2016	Fee-for-service	Mandatory	To (1) improve quality of care and life of residents; (2) improve employee standard of living; (3) address workforce needs; (4) improve resident dignity/privacy; (5) support nursing facility access throughout the state; (6) improve resident/employee environment; and (7) make the payment system more understandable for policymakers and providers. ^g
Ohio: Nursing Home Quality Incentive System	2009	Fee-for-service and managed care	Mandatory	To help improve health outcomes for residents of nursing facilities and incentivize better performance within the NF community. ^h
Ohio: Enhanced payment for ventilator-dependent residents	2017	Fee-for-service and managed care	Voluntary	To ensure ventilator-dependent NF residents receive high quality clinical care. ⁱ
Tennessee: Quality Improvement in Long Term Services and Supports (QuILTSS)	2014	Managed care	Voluntary	To promote the delivery of high quality LTSS by aligning payment with value-based on performance on measures that most impact the experience of persons receiving LTSS and their family/caregivers. ^j
Texas: Quality Incentive Payment Program (QIPP)	2017	Managed care	Voluntary	To promote a resident-centered care culture through facility design and services provided. ^k

Note that more detail on these initiatives is in Appendices 1 and 2.

SOURCES:

- ^a Arizona Contractors Operation Manual (ACOM). "Arizona Long Term Care System Elderly and Physically Disabled Program Payment Reform Initiative." Chapter 318, CYE 15, effective 10/01/2014. Available at <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/318.pdf>.
- ^b Arizona Health Care Cost Containment System (AHCCCS). Arizona Long Term Care System (ALTCS) Elderly & Physical Disability (E/PD) Program Contract for Contractors: Solicitation # YH18-0001 ALTCS E/PD. January 2017. Available at https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp_Solicitation.pdf.
- ^c Fletcher, Chris and Kris Knerr. "Nursing Home Value-Based Purchasing Operational Issues." Presentation to the Long Term Care Value-Based Purchasing Invitational Meeting, Atlanta, GA, March 11, 2015.
- ^d Taylor, Erin and Michael Bailit. "Integrated Care System Partnerships (ICSP) Evaluation: Final Recommendations to the Minnesota Department of Human Services." August 26, 2016. Available at: <http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs-290119.pdf>.
- ^e Minnesota Department of Human Services. Minnesota Nursing Facility Performance-based Incentive Payment Program. Summary provided by Teresa Lewis on 1/11/17.
- ^f Minnesota Department of Human Services. Minnesota Nursing Facility Quality Improvement Incentive Payment Program. Summary provided by Teresa Lewis on 1/11/17.
- ^g Minnesota Department of Human Services. Minnesota Nursing Facility Value-Based Reimbursement System. Summary provided by Teresa Lewis on 1/11/17.
- ^h Interview with Kim Donica and Cheryl Guyman, Ohio Department of Medicaid, February 9, 2017.
- ⁱ Ibid.
- ^j Killingsworth, Patti. "TennCare Health Care Innovation: Long-Term Services and Supports (LTSS) Value-Based Purchasing Initiatives." Presentation to the Provider Stakeholder Group Meeting, Nashville, TN, May 21, 2014. <https://www.tn.gov/assets/entities/hcfa/attachments/May14ProviderMeeting.pdf>.
- ^k Texas Health and Human Services Commission. "Texas Quality Incentive Payment Program Concept Paper." January 20, 2016. Available at: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/provider-information/qipp-concept-paper.pdf>.

for regional price variation and other factors.¹³ Most Medicaid nursing facility per diem rates are calculated as the sum of several cost components (i.e., direct care, indirect care, administration or operating and capital/property-related), and may be facility-specific, peer-grouped, or set to a fixed, statewide amount. Most Medicaid nursing facility payment systems include adjustments for resident acuity or case mix. Pay-for-performance adjustments based on quality measures are becoming increasingly popular.¹⁴ Like Medicare Advantage plans, managed care plans that contract with states to deliver Medicaid services tend to model nursing facility payments on state Medicaid FFS reimbursement systems.

Rewards Based on Value

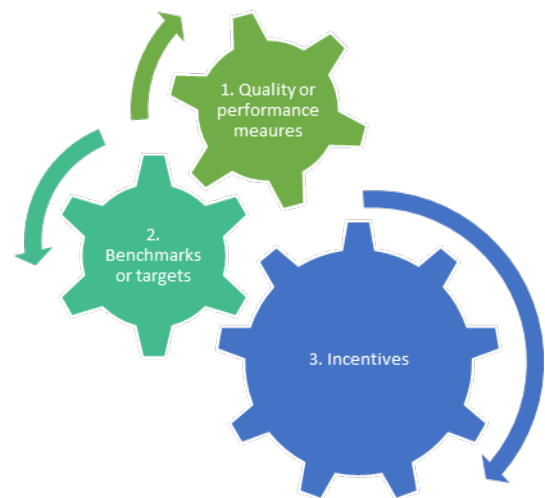
VBP can offer facilities additional performance-based payment incentives above and beyond the reimbursement they would otherwise receive. There are several VBP strategies, including: (1) initiatives that link payment to quality and value (e.g., pay-for-performance, pay-for-reporting, or bundled payments for episodes of care that offer bonuses based on performance measures); (2) models that allow for gain sharing (e.g., shared savings programs that include upside and/or downside risk); and (3) population-based payment (e.g., based on specific conditions or comprehensive measures). States and managed care plans, including those interviewed for this brief, have tended to rely heavily on a pay-for-performance model of VBP in which providers receive additional payment for meeting pre-established quality benchmarks or targets on performance measures that assess both short-stay skilled care (e.g., avoidable inpatient admissions, and readmissions) and long-stay custodial care (e.g., residents experiencing pressure ulcers, falls, or urinary tract infections). These rewards are intended to motivate providers to change behavior so as to deliver higher quality of care and achieve better outcomes for residents.

Framework for VBP

All VBP approaches, including those used for nursing facilities, have three components (see Exhibit 2).

1. **Quality or performance measures** assess specific aspects of care provided within a facility, such as the number and type of services that residents use, clinical outcomes, functional status, experience of care, or the administrative compliance or efficiency of a facility. VBP approaches can incorporate nationally standardized quality measures endorsed by the National Quality Forum or those reported in CMS' Nursing Home Compare and Five-Star Quality Rating System,¹⁵ to examine aspects of care or facility administration that are of interest to a particular state (e.g., timely submission of required reports or staffing ratios).
2. **Benchmarks or targets**¹⁶ specify the measure value or threshold that a facility must reach to receive an incentive. Such values are usually pre-established for a given measurement period and can be: (a) absolute, requiring a facility to meet or exceed a pre-specified value; (b) relative, requiring a facility to score within a certain value range relative to other participating facilities; or (c) self-improvement based, comparing a facility's performance to itself in prior years. Absolute targets provide a clear motivation for facilities to improve on care; however, payment based on absolute values may benefit well-performing facilities at the expense of facilities that have the most

Exhibit 2. Three Components of VBP



to gain in terms of quality improvement. It may also be difficult for states to find universally acceptable and actionable targets. Alternatively, relative targets can encourage progress from facilities at all levels of experience, particularly if participating facilities have similar experience and performance at the outset. However, evaluating a facility relative to its peers may create a moving target that is difficult to achieve. Rewarding improvement is important for the lowest performers; by getting credit for meeting an improvement threshold, it gives them greater incentive to improve even if they cannot achieve an absolute target or their performance is well below the median.

3. **Incentives** typically refer to financial awards for achieving specified quality benchmarks, which can vary in absolute amount and share of revenue. States or plans can also increase payment to facilities that meet benchmarks and/or decrease payment for those that fall short. Payments can take the form of one-time add-ons or recoupments, or changes to a base rate that carry forward over future years. States can also use non-financial incentives, such as sharing quality or performance measurement results with the facility or the public, or designating and advertising top-performing facilities as “centers of excellence” to make these facilities more attractive to prospective residents looking to select among multiple facilities. For example, CMS’ Nursing Home Compare Five-Star Rating System rewards high-performing nursing facilities by advertising their quality to individuals who are searching for public information online.

In designing VBP programs, states must consider the interaction of measures, targets, and incentives. Selecting the “right” set of quality measures and targets tied to an incentive depends on the goals a state is trying to achieve as well as real-world constraints on facilities (e.g., reporting capabilities or a facility’s capacity for change). These goals, as well as constraints, may vary greatly across states and facilities, requiring a state to select a set of measures and related targets that align with the “Goldilocks principle”—they are neither too hard nor too easy. In selecting measures for its VBP strategy, Texas followed this principle by selecting a narrow range of measures that reflected the state’s goals; some measures had targets that were easily achievable (e.g., reducing the use of restraints) and others represented aspirational goals (e.g., reducing the use of antipsychotics) relative to current facility performance. To follow the Goldilocks principle, states should select measures and targets that are:

“VBP is about creating a culture of recognition around the role that facilities play in improving quality. The role is that they are receptive and responsive to onsite clinical care, the goals of care, involving families in decisions, and communicating the risks involved in transitions of care.”

—Managed care plan official

- **Understandable**, meaning facilities know what they are being measured on and can tie measure change to specific practices within the facility;
- **Valid and reliable**, meaning measures can be calculated using statistically sound methods that produce representative results;
- **Fair**, meaning one facility is not advantaged over another;
- **Achievable**, meaning all facilities have the opportunity to implement practices that have been demonstrated to improve performance on the measures, and
- **Worth the effort**, meaning that the additional payment a facility can earn is greater than the cost of implementing the changes required to meet the reward targets.¹⁷

Considering the range of possible approaches to measures, targets, and incentives, states can either develop their own VBP programs or encourage managed care plans to do so. There are advantages and disadvantages to each approach:

- **State-initiated programs** often cover nursing facilities that are paid FFS as well as those covered by managed care, as plans are required or encouraged to replicate the VBP approach under FFS. The

advantage to a state-initiated approach is that it can provide a single, aligned set of measures, targets, and incentives for all facilities across payers. However, developing and administering VBP at the state level can be resource-intensive, requiring dedicated staff and funds.

- **Plan-initiated programs** allow for more variation in VBP by recognizing differences in local needs and priorities. Plans may also provide up-front funding to support program implementation costs. Plan approaches are often voluntary, however, and if the plans' programs are not well designed, it may discourage poor performers or less motivated providers from participating and improving quality. In addition, where managed care plans cover a relatively small portion of a facility's residents, the effectiveness of VBP payments to incent care quality improvements may be relatively low.

VBP Approaches Currently Used by States

Reflecting the three components of VBP presented above, the following section describes the range of VBP approaches for Medicaid-covered stays in nursing facilities currently used by the states interviewed for this brief (summarized in Exhibit 1, with more detail in Appendices 1 and 2). Many of the states featured in this brief have designed VBP programs that reward facilities based on measures of both short- and long-term stays, and whether Medicaid-covered residents (dually eligible or not) receive high-quality care. Regardless of the VBP design, the states interviewed for this brief stress the importance of consultation and collaboration with stakeholders – which could include facilities and their trade associations, managed care plans, clinicians, advocates, state agencies responsible for nursing facility oversight, and entities with expertise in quality measurement – in all aspects of design. Providing technical assistance to managed care plans and/or facilities and evaluating their programs to ensure they operate as intended was emphasized as well.

CMS Nursing Home Compare Five-Star Quality Rating System

As part of its *Nursing Home Compare* website, CMS calculates “Five-Star” measures of quality for 15,000+ Medicare and Medicaid nursing facilities across the country.¹⁸ In this system, each nursing facility is given an overall rating of one to five stars, based on performance in three domains:

- **Health inspections:** This domain is based on the three most recent annual state health inspections, as well as the most recent 36 months of complaint investigations, weighted by scope and severity of deficiencies.
- **Staffing:** This domain is based on the total registered nurse hours per resident day and the total staffing hours per day, which includes registered nurse, licensed practical nurse, and nurse aid hours. These hours are adjusted by Resource Utilization Group (RUG) case mix, based on the distribution of Minimum Data Set (MDS) assessments by RUG, and self-reported through the CASPER system.
- **Quality measures:** This domain is based on a subset of the 24 quality measures posted on the Nursing Home Compare website. Measures for long-stay residents include the percentage who: (1) have an increased need for help with activities of daily living; (2) have a worsened ability to move independently; (3) have pressure ulcers; (4) have/had a bladder catheter; (5) were physically restrained; (6) have a urinary tract infection; (7) self-report moderate to severe pain; (8) experience fall(s) with major injury; and (9) received antipsychotic medications. Measures for short-stay residents include 3, 6 and 7 listed above, as well as the percentage who: (10) experienced an improvement in physical functioning from admission to discharge; (11) were re-hospitalized after a nursing facility admission; (12) had an emergency department visit; and (13) were successfully discharged to the community. Measures 1-10 are based on resident information that nursing facilities collect with the MDS assessment form, and measures 11-13 are based on Medicare hospital and emergency department claims.

Quality or Performance Measures

As shown in Appendix 1, states vary in the number and variety of measures used in their VBP programs, ranging from a single measure in specialty programs in Arizona to various measures compiled into six state-specified domains in Indiana.¹⁹ All 11 VBP programs in the six states profiled in this brief link value-based payments to quality measures that assess clinical care quality (e.g., pressure ulcers, falls, urinary tract infections, vaccination rates, and use of antipsychotics). Half of the state programs also incorporate measures of resident experience, often collected from resident surveys. Four of 11 state programs have utilization measures, such as avoidable hospital admissions from nursing facilities, hospital readmissions within 30 days, and emergency department use, which are viewed as sentinel indicators of care quality in all settings, including nursing facilities. Less common is the use of staffing measures (e.g., staff time, retention) and certain treatments (e.g., use of restraints). Two states – Tennessee and Texas – also incorporate administrative measures, such as submitting accurate data, reports, or in the case of Tennessee, the timely payment of state mandated taxes or fees used, in part, for quality payments.

Data that support measures for VBP generally come from one of three sources. Some states use national measures available from CMS, such as those included in CMS' Five-Star ratings, which are derived from Minimum Data Set (MDS) resident assessments or information from facility inspections and staffing information drawn from the Certification and Survey Provider Enhanced Reporting (CASPER) system.²⁰ Tennessee and Texas use such measures, at least in part (see *CMS Nursing Home Compare Five-Star Quality Rating System* for more information). Some states (Indiana, Minnesota, Ohio, and Tennessee) design their own measures based on CASPER data, Medicaid claims data, MDS data, nursing facility payroll data, or surveys of resident satisfaction. Some states like Minnesota also have their own state-specific report cards that feed into VBP programs, augmenting the measures available from CMS. In the case of Minnesota, using measures from the state's Nursing Home Report Card in its VBP strategy allows it to make payments based on dimensions like quality of life, family satisfaction, staff retention, use of temporary staff, or facility environment, which are not available from CMS.

States with VBP programs must also consider whether the data feeding the measures are accurate and reliable. Claims-based measures require an accurate record of the services rendered. Measures of facility compliance require surveyors to report deficiencies and assign penalties in a consistent manner. Measures of facility costs often require the facilities themselves to submit accurate financial data, which must be verified through audits, while measures of resident satisfaction require that surveys are administered to residents in an objective way.²¹

When managed care plans are required to construct measures from their own data sources and report them to the state, the measures should also be validated by an independent entity. Arizona, for example, requires that managed care plans self-report calculated measures of overall care quality in nursing facilities, but the state validates them using encounter data. Texas relies on its plans to pass through payments to facilities based on VBP scores. To ensure that payments are being correctly distributed to facilities, Texas plans to survey a random sample of managed care plans and calculate the amounts plans pay to facilities. Any over- or underpayments will be returned to the plan or facility. Tennessee is also in the process of engaging a contractor to develop and implement an ongoing process to audit data – particularly outcomes-based measures – reported for the purposes of VBP.

Benchmarks or Targets

Despite variation in the number of measures and domains covered in state VBP programs, most states interviewed for this brief distribute incentives (typically payments) based on a facility's performance relative to its peers. See Appendix 2 for a summary of the measure targets as well as the payments available for achieving the targets. In some state programs, like Arizona's value-based payment differential, facilities receive payment based on their performance relative to an average score across all participating facilities on

measures of pneumococcal and influenza vaccination rates. In Ohio's Nursing Home Quality Incentive System and in Indiana, nursing facilities can receive payment if they score within a certain measure percentile, defined by the relative performance of peer facilities. Ohio's measures include potentially avoidable inpatient admissions from nursing facilities, pressure ulcers, antipsychotic medication use, and resident experience and employee retention; Indiana's measures include items related to care and services, resident rights, and other domains from its Nursing Home Report Cards, as well as several additional staffing measures. Alternatively, Ohio makes enhanced payments for ventilator-dependent residents and a facility may be penalized by up to five percent if its ventilator-assisted pneumonia rate is above the statewide average and it fails to improve on this measure.

States are not limited to defining a single performance target for each measure. Minnesota's Quality Incentive Improvement Program, for example, allows facilities to earn payment for meeting one of two possible targets: (1) reaching the statewide 25th percentile; or (2) improving one standard deviation relative to a facility baseline on measures of quality of care or quality of life selected from the Minnesota Nursing Home Report Card, whichever represents the greatest improvement. State staff negotiate individual targets with each facility in Minnesota's Performance-based Incentive Payment Program, depending on the measures and the facilities' baseline rates.

Incentives

Appendix 2 also summarizes the range of incentive approaches that states interviewed for this brief currently use, all of which provide additional payment to high-performing facilities. Though most states develop a single VBP structure that rewards quality with payment, some allow managed care plans to identify a strategy that fits their needs and earn payment relative to the proposed design. States that rely on managed care plans to propose a VBP strategy may allow a wider range of payment approaches from among the participants, which could include shared savings.

The amount that facilities can receive under the approaches examined for this brief vary based on funds available in each state, but the payment can represent an increase of up to six to eight percent of a facility's Medicaid daily rate (as in Indiana). Beginning in October 2017, Arizona will also allow facilities to be designated as "centers of excellence" in order to provide an additional incentive outside of any payment rewards they receive.

States also use a variety of funding sources to support value-based payments. Several states (Arizona, Indiana, and Tennessee) use taxes levied on nursing facilities, sometimes referred to as "quality assessment" fees, to fund VBP. Other states (Minnesota and Ohio) use state general funds or Medicaid funds. Texas relies on intergovernmental transfer funds from public facilities, which it can use to draw down additional federal Medicaid matching funds.

Lessons Learned for the Structure of VBP

While two states have been operating VBP programs for over a decade (Minnesota's Performance Based-Incentive Payments for Nursing Facilities began in 2006 while Indiana's VBP initiative began in 2005), the remaining states featured in this brief have been operating VBP programs for less than five years. Taken together, their experiences can offer valuable lessons to other states that are interested in designing similar VBP programs. Specifically, experienced states suggest that those new to VBP:

- **Align measures in VBP programs with those reported by CMS' Nursing Home Compare Five-Star Rating System.** Ohio officials, in particular, stressed the importance of aligning measures with those used to rate facilities nationwide. The state's initial VBP program included 22 measures that were calculated using facility-reported data; facilities had to meet goals in five of the 22 measures to

earn payment. However, the state found that some facilities earning full payments received 1-Star ratings from Medicare, suggesting that the measure benchmarks were too low and the state's measurement approach was not achieving its quality objectives. In redesigning its program, Ohio not only aligned the measures with those used in CMS' recent quality improvement projects, but it also looked for correlation between a facility's quality score and its CMS Five-Star ratings. This approach reduces data and measure reporting burden for facilities and the state. For an explanation of the CMS ratings, see *CMS Nursing Home Compare Five-Star Quality Rating System*

- **Standardize data collection methods or instruments across facilities.** When facilities report data that has been collected or calculated consistently, a state can compare measures more reliably. States that develop their own data collection instrument or use one developed by a national vendor can ensure that facilities report data in the same way. Tennessee, for example, has support from its nursing facility community to standardize the tools and processes used to measure satisfaction and person-centered care quality and begin to make comparisons across facilities. Existing facility contracts with survey vendors (some of which operate in facilities across multiple states) have made it challenging to mandate the use of a single tool, but the state is moving toward a more standardized outcomes-based measurement approach thanks to buy-in from its stakeholders.

"We have always approached our VBP program as an evolving process. We have made it clear to our contractors and facilities that measures and requirements will change over time, as we learn what works best."

—Arizona state official

- **Approach the quality measures that inform VBP as a work in progress and adjust over time as needed.** Over time, states should update the set of measures and targets that facilities must meet to receive payment under VBP to ensure measures are strong, quality objectives are clear, and VBP programs continuously raise the bar on quality standards to drive performance improvement. When they began their programs, some states included a few measures and benchmarks that were easy to attain or on which nursing facilities already demonstrated high performance (e.g., influenza vaccination rates). By setting the bar low initially, these states believed that facilities would grow accustomed to reporting data and change facility practices to raise measure performance. However, this allowed low-quality facilities to appear better than their performance warranted on critical aspects of quality.

The states interviewed for this brief stressed the importance of reassessing measures and benchmarks used to ensure that facilities are encouraged to continuously improve quality on a broader set of measures over the life of the program. Arizona, for example, based its original VBP differential on quality measures from CMS Nursing Home Compare score. Managed care plans are considering adding staffing measures over time, as the Nursing Home Compare Star Ratings system has done. While it is important to include a broader set of measure domains, the number of measures should be manageable. Indiana, which started out with a relatively large set of measures tied to its VBP program, has chosen to limit the number of measures it collects. State officials caution that having too many metrics can make it difficult for facilities to understand the financial incentives and change their performance.

- **Adjust the size of payments available under VBP to make it worthwhile to participate.** In addition to raising expectations on quality and performance over time, states should consider whether the size of the financial incentive – whether structured as a reward (all states) or penalty (possible in Minnesota's Performance-based Incentive Payment Program program) – is sufficient to motivate change. Officials in Indiana advise that "the more money a state can tie to an initiative, the better the outcomes achieved. If there is only a [small amount] of revenue tied to an initiative, facilities will consider the costs and benefits, and decide that changing their behavior isn't worth it."

- Consider adjustments to the underlying Medicaid FFS nursing facility reimbursement system to facilitate VBP.** Managed care plans typically start with the existing nursing facility FFS payment structure and rates when determining how to pay nursing facilities in their networks, since that can avoid undue disruption in nursing facility billing and payment. The value-based payments are generally incremental modifications to that underlying system. If, however, the underlying system has financial incentives that conflict with VBP – like paying a flat daily rate for all residents irrespective of their care needs – the incremental value-based payment adjustments may have limited impact.

Officials in Indiana also stressed that the biggest tool states have to effect change and move providers towards higher quality is the structure of the Medicaid reimbursement system for nursing facilities. Medicaid reimbursement for covered services often represents a third or more of a facility’s total payment from all sources.²² This is true of both states that pay nursing facilities on a FFS basis as well as those that cover facilities under managed care, since managed care plans typically pay facilities the state-established FFS rates. Changing the amount allocated to various components of a nursing facility rate can affect quality (e.g., increasing the amount for direct service costs relative to administration can help support aspects of care that most directly affect quality of life). In addition, nursing facility cost reports to the state that include detailed information on the components of direct service costs, such as actual nurse and therapist staff hours, can provide a basis for VBP payments.²³

Adjusting components of the rate based on quality scores may also have an effect. Arizona, for example, has increased payments to nursing facilities by one percent for meeting or exceeding the Arizona average Medicare Nursing Home Compare score for the pneumococcal vaccination rates and another one percent for meeting or exceeding the average on influenza vaccination rates.²⁴ Ohio enhances payments to facilities for ventilator-dependent residents, but if the rate of ventilator-associated pneumonia for these residents exceeds the state average, facilities may be penalized up to five percent of their rates per quarter. In both states, managed care plans are required to pay the FFS rate, thereby passing on the enhanced payments to providers.

Lessons for the Development, Administration, and Improvement of State VBP Programs

In addition to carefully structuring VBP programs, states must also consider the process for developing, administering, and assessing VBP programs. Following are state examples and lessons related to stakeholder involvement, technical assistance, and evaluation:

- Involve a broad range of stakeholders in developing the program.** All of the state officials interviewed for this brief reported working closely with stakeholders to help design and develop their VBP programs. The number and range of stakeholders varied by state but generally included facilities and their trade associations, managed care plans, clinicians (such as geriatricians), advocates, state agencies involved in nursing facility oversight (such as the Department of Aging and ombudsman), and agencies or entities with expertise in quality measurement (e.g., the Department of Health, local universities). Tennessee, for example, uses a stakeholder group composed of industry and provider representatives, family and resident advocates, and agency officials who have responsibility for quality oversight activities (such as representatives from the survey agency and the Medicare quality improvement organization, which is also the state’s Medicaid external quality review organization). State officials report that broad representation helps balance interests and perspectives, and ensures an overarching commitment to quality assurance and performance improvement.

"Include industry and clinical experts from the beginning; the more, the better. This makes quality improvement difficult to argue against and helps people feel that they were a part of the process."

—Indiana state official

- **Provide technical assistance to participating facilities.** A number of state officials emphasized the importance of providing technical assistance to managed care plans and/or facilities participating in VBP, particularly for new or complex initiatives. Arizona, for example, regularly meets with individual managed care plans and holds meetings that include all plans each quarter, during which the state provides technical assistance and plans present lessons learned. Minnesota holds an annual, multi-day “boot camp” to connect VBP-participating facilities to each other and to state resources that can support quality improvement project development. Minnesota officials report that this intensive technical assistance is particularly helpful for independent, free-standing facilities that might not have the corporate resources to devote to the application process for VBP or may otherwise be intimidated by it. Tennessee supported technical assistance with grant funding from the Robert Wood Johnson Foundation, contracted with a local university to provide in-person training when VBP began, and archived all trainings and associated materials for facilities to use when they begin participating. Regardless of its format, technical assistance not only helps facilities to participate in VBP, but it also nurtures relationships between payers and providers that support care quality more broadly.
- **Evaluate program outcomes.** To date, the evidence on the impact of VBP for nursing facilities is mixed, possibly due to shortcomings in program design.²⁵ Therefore, states that invest significant resources in VBP should consider using rigorous methods to evaluate program impact. Such methods should compare trends among participating facilities to a similar group of non-participating facilities, and control for differences in facilities’ baseline performance and characteristics.²⁶ States that do not have in-house resources to conduct rigorous evaluations can partner with local universities. For example, Minnesota evaluated its Performance-based Incentive Payment Program by partnering with academic researchers supported by a grant from the Agency for Healthcare Research and Quality. The evaluation compared participating and non-participating facilities on a composite measure of quality, and incorporated feedback about the program’s administration and perceived impact from project leaders and facility staff. The analysis showed a 13 percent improvement in clinical quality over baseline; additional results were published in two peer-reviewed journals.^{27,28} CMS has used a similarly rigorous analysis in its evaluation of the Medicare Nursing Home Value-Based Purchasing Demonstration to develop lessons for program design, implementation, and evaluation that could help states avoid some of the shortcomings identified in that demonstration (see *Lessons from CMS’ Medicare Nursing Home Value-Based Purchasing Demonstration*).

Officials in several states described using “soft metrics” to measure the progress of VBP programs; that is, these states monitor increases in the number of facilities participating in the initiative, number of facilities receiving payment, or average quality scores over time to track indicators of quality improvement. However, without comparing trends to those occurring in non-participating facilities, or to the trends occurring in participating facilities before and after VBP was in place, it is difficult to know whether changes observed in quality measures result from VBP or other external factors.

VBP Approaches Currently Used by Managed Care Plans

Comparing VBP Approaches Used by Managed Care Plans and States

Several managed care plans – either aligned with or independent of state efforts – are using VBP approaches to provide incentives to improve care within their network of nursing facilities. Discussions with five national and regional managed care plans indicate that many of the VBP approaches initiated by plans are similar to those initiated by states. For example, plan-initiated approaches tend to base payment on similar measures of quality and use similar sources of data for Medicaid, though they may also measure cost, care coordination processes (e.g., notifying the plan within 24 hours of a facility resident entering a hospital), or administrative requirements for which they have readily available data (e.g., submitting electronic claims and using e-

prescribing). Like states, the plans interviewed for this brief have also taken an incremental approach to VBP for nursing facilities by modifying measures over time and gradually increasing the amount of payment available to facilities, when the original program design did not allot enough to incent the desired changes.

Managed care plan-initiated approaches to VBP differ from state-initiated approaches in that they often allow more flexibility. That is, while most of the states featured in this brief – except Arizona and Minnesota – have prescribed models in which all participating facilities in the state are working on a standard set of measures to earn a specified payment, most plans vary the quality measures and reimbursement structures to accommodate differences in product lines and facilities. Particularly among national plans, this flexible approach to VBP

Lessons from CMS' Medicare Nursing Home Value-Based Purchasing Demonstration²⁹

Overview of the demonstration. From July 2009 through June 2012, CMS tested the concept of VBP in 171 nursing facilities in Arizona, New York, and Wisconsin. CMS measured facilities on four domains: (1) staffing and turnover; (2) potentially avoidable hospitalizations; (3) survey deficiencies; and (4) MDS-based resident outcomes, changes in activities of daily living, pressure ulcers, bladder incontinence, and use of catheters and physical restraints. Facilities that performed in the top 20 percent overall or in terms of improvement received incentive payments, with the top 10 percent receiving higher payment; those with a high number of hospitalizations were ineligible for payout. Each year, CMS determined the amount of payment available to facilities relative to the amount of Medicare savings all facilities in a state could generate, limited by budget neutrality rules to no more than 5 percent of total Medicare expenditures.

Results. An evaluation of the NHVBP demonstration found that payments to facilities were infrequent and their impact on quality was minimal. Only three of the nine state-year evaluation periods resulted in payments to the top performing facilities because participants in a given state could not always generate sufficient savings to Medicare. There was also little change in performance between the treatment and controls groups across the periods before and after the NHVBP demonstration was in place. Even among the top performing facilities, interviews suggest that facilities participating in the demonstration did not change their operations in any way. The evaluation suggested that the design and administration of the NHVBP demonstration limited it from being more effective. In terms of design, the methods of calculating the payments and rewards were complex, so nursing facilities may not have understood how their efforts towards improving quality would result in payment. Even if they did understand the incentives, Medicare's restrictions on the amount of payment available to facilities made the incentives too small to prompt changes in quality. Moreover, the amount of savings available depended on the collective ability of all facilities in a state to generate savings to Medicare, which reduced the motivation for individual facilities to improve their quality. In terms of process, the demonstration relied on administrative data to calculate savings and performance, and CMS did not make payouts to top performing facilities until nearly 18 months after facilities would have begun investing in quality improvement. CMS also provided limited guidance or education to facilities to help them improve quality, which challenged facilities that lacked the infrastructure and expertise to improve on their own.

Lessons for states. NHVBP demonstration findings suggest that states designing nursing facility VBP programs should:

- Use simple rules to govern payment and reward;
- Ensure that the payment available to facilities is significant relative to their other sources of revenue;
- Avoid conditioning payment to a single facility on the effort of its peers;
- Offer timely payouts to facilities;
- Provide real-time feedback to facilities on performance and quality improvement; and
- Support facilities through education and guidance (e.g., by providing technical assistance or requiring certain trainings to qualify for payment).

Future plans. CMS is planning to implement a Medicare SNF VBP program beginning in 2019 that has been re-structured, based on the lessons learned from the Nursing Home Value-Based Purchasing Demonstration.³⁰

may help address variation in LTSS system features across states and regional markets—an option states new to VBP may look to replicate. One national plan that operates in Arizona, for example, reported that it has structured its VBP program in that state to recognize that the state has very substantially reduced institutional care over time so that only about 25 percent of members are currently living in nursing facilities, most of whom have limited ability to transition to living in the community. Therefore, the plan has focused on a number of key acute care measures that have a direct impact on a member's health in the facility (e.g., rate of bed sores, hospitalization readmissions, flu shots, nursing facility notification to plan of hospitalization, etc.). In other states that provide more institutional care relative to HCBS, this health plan is structuring its VBP to provide incentives for nursing facilities to assist in transitioning members to the community.

Plan-initiated VBP approaches also differ from those of states in the extent to which their financial leverage can create incentives for change in facilities. Where the number of plan enrollees residing in a given facility is small, plans may find it difficult to generate statistically valid measure results. Plans, as well as state Medicaid agencies, may also find that reward payments to a given facility may be small relative to a facility's total managed care plan or Medicaid revenue; thus, the incentive for a facility to change behavior is low. The effect of small payments may be exacerbated when a facility is subject to other, potentially conflicting, payment incentives from other managed care plans. Unlike some states, plans initiating their own VBP approaches must also fund them using existing revenue streams, with VBP funds coming from per member per month capitation rates received from the state.

Opportunities for VBP in Medicare-Medicaid Plans

Medicare pays for almost all hospital services for Medicare-Medicaid enrollees, while Medicaid pays for most long-term nursing facility services, creating financial incentives for Medicare and Medicaid to shift the setting and cost of care to the other payer.³¹ Such cost shifting can result in unnecessary hospital admissions and readmissions for nursing facility residents, which are both expensive and indicators of potentially inadequate care in the nursing home.³² Because integrated care plans are responsible for all covered services for Medicare-Medicaid enrollees, they can reap the benefits of any investments in nursing facility care that reduce unnecessary inpatient and SNF care.

Plans that cover Medicare-Medicaid enrollees and receive integrated Medicare and Medicaid funding are in a better position to structure a VBP program without considering which payer will benefit from the savings. One plan in Minnesota (see *Integrated Measures for Medicare-Medicaid Enrollees in HealthPartners' Partnership Homes*) explicitly constructed its VBP program in this way. Another plan in Arizona characterized its VBP program as measuring care irrespective of payer, using measures of inpatient hospital readmissions, emergency room visits, and long-term care. Because the plan is fully at risk for all medical and long-term care costs for more than half of its membership, the plan was able to create a sufficient savings pool to make the VBP program effective.

Integrated Measures for Medicare-Medicaid enrollees in HealthPartners' Partnership Homes

Through its Partnership Homes program, HealthPartners – a large managed care plan in Minnesota – offers value-based incentive payments to participating facilities that perform better than the facility average on two quality of care measures: (1) the percentage of residents who experience falls with injury; and (2) the percentage of residents with facility-acquired pressure ulcers. Because HealthPartners receives blended Medicare and Medicaid funds for dually eligible beneficiaries covered through the Minnesota Senior Health Options (MSHO) program, it has chosen to calculate these two measures irrespective of the portion of a stay being covered by Medicare versus Medicaid. This approach helps the plan measure quality in a comprehensive way and may encourage nursing facilities to improve care quality for both post-acute and custodial stays.

Conclusion

States and managed care plans interested in developing VBP strategies for nursing facilities can learn from the examples of their peers, as well as lessons from the Medicare Nursing Home VBP demonstration. States and plans new to VBP should consider aligning nursing facility quality and performance measures with those reported by CMS' Nursing Home Compare Five-Star Rating System and standardize data collection methods and/or instruments across facilities. They suggest that financial rewards under VBP be sizeable enough to encourage change within facilities and suggest that the underlying reimbursement structure work in harmony with the payment incentives provided under VBP. State officials interviewed for this brief also recommend strategically selecting stakeholders to engage in VBP program design, and providing technical assistance to participating facilities to help ensure the program's success.

To date, the evidence on the impact of VBP for nursing facilities is mixed, possibly due to shortcomings in program design.³³ This suggests there is room for improvement in the next generation of VBP programs. States and plans now engaged in this effort stress the importance of continually assessing and improving program design to ensure that it is achieving its objectives.

Progress in the development of nationally standardized measures for managed LTSS plans can also help to strengthen VBP programs for states and managed care plans that wish to improve the quality of care across settings where people receive LTSS. As nationally endorsed measures of MLTSS become available, such as those related to successful discharge of members with short-term institutional admissions and successful transition to the community of members with long-term nursing home stays, states and plans will be able to target VBP programs to improving care across the continuum of long-term care.

States and managed care plans that blend Medicare and Medicaid funding have a unique opportunity to use VBP to encourage improvements in the quality of nursing facility care for Medicare-Medicaid enrollees who often move between skilled/rehabilitation and custodial stays in nursing facilities. However, this brief found few examples of VBP initiatives that fully integrate financial incentives across short- and long-term stay facilities. Similarly, it did not uncover clear evidence on how states can structure managed care plan capitation payments so that savings that accrue to plans by improving quality – that is, the “value” in VBP – will be shared with state Medicaid agencies. Nevertheless, states or plans that wish to develop such initiatives can draw from the lessons in this brief by measuring facilities on services and outcomes that require coordinated medical and custodial care, or by using alternative payment strategies that allow providers to share in additional risk and rewards based on both Medicare and Medicaid services and payments.

Appendix 1. Quality Measures and the Portion of the VBP Financial Reward They Represent

State and Program	Total Measures or Domains (Measurement Year)	Categories of Measures or Measurement Domains (portion of total payment for participating facilities attributed to each measure, if known)				
		Utilization	Clinical Care Quality	Resident Experience	Staffing and Staff Experience	Other
Arizona: VBP Initiative ^a	5 measures (2016)	Readmissions within 30 days (20%); ED utilization (20%)	HbA1c testing (20%); LDL-C screening (20%); flu shots - age 18+ (20%)			
Arizona: Value based payment differential ^b	2 measures (2018)		Pneumococcal vaccination rates and influenza vaccination rates; 1% differential payment increase for each; potential 2% total			Differential based on meeting or exceeding state rate average based on Medicare Compare measures
Indiana VBP Initiative^{c,d}	6 domains (2017)		Care and Services measures from the Nursing Home Report Cards (Report card measures represent 75% of score)	Resident Rights measures from the Nursing Home Report Cards (Report card measures represent 75% of score)	Average nursing hours per resident day; retention rate for RN/LPNs and CNAs; turnover rate for RN/LPNs, CNAs, administrator, and director of nursing (staffing measures represent 25% of score)	Environment, Dietary Services, and Administration measures from the Nursing Home Report Cards (Report card measures represent 75% of score)
Minnesota: Integrated Care System Partnership (ICSP) ^e	22 possible measures; managed care plans select measures to include in subcontract arrangements (2015)	Outpatient visits; ED visits; ambulatory care sensitive conditions admission rates; inpatient utilization; plan all-cause readmissions; potentially preventable re-admissions	Care of older adults; fall with fracture; use of high risk medications in the elderly; annual monitoring of patients on persistent meds; depression screening; fall risk management; flu shots for older adults; medication reconciliation post-discharge; pneumococcal vaccination status for older adults; pressure ulcers; screening for cognitive impairment; reduced risk of falls/falls screenings/fall risk management; use of antipsychotics for people with dementia			Evidence of physician order for life-sustaining treatment with person specific goals for residents with 90 days or more stays; advanced care planning; follow protocol prior to sending to ED or inpatient

State and Program	Total Measures or Domains (Measurement Year)	Categories of Measures or Measurement Domains (portion of total payment for participating facilities attributed to each measure, if known)				
		Utilization	Clinical Care Quality	Resident Experience	Staffing and Staff Experience	Other
Minnesota: Performance-based Incentive Payment Program (PIPP) ^f	10 domains including 21 possible measures of quality of care; 12 possible measures of quality of life (2016)	Short- and long-stay hospitalization rates; community discharge	21 possible quality indicators from the Minnesota Nursing Home Report Card covering psychosocial condition, restraints, continence, infections, accidents, nutrition, skin care, psychotropic medications, physical functioning, and pain	12 measures from the Minnesota Nursing Home Report Card covering comfort, environmental adaptations, privacy, dignity, meaningful activity, food enjoyment, autonomy, individuality, security, relationships, satisfaction and mood	NFs often use direct-care staff retention alongside its resident-focused performance measures for staff-focused PIPP projects. The state does not allow direct-care staffing hours to be used as a PIPP outcome, but does post them on the MN Nursing Home Report Card.	Family satisfaction; short stay experience (available 2017)
Minnesota: Quality Incentive Payment Program (QIIP) ^{f, g}	1 of 33 Minnesota Nursing Home Report Card quality of care or quality of life measures		NFs select one quality of care or quality of life measure from the Minnesota Nursing Home Report Card to improve using their choice of intervention(s). In 2013, the first year of the program, 320 NFs (89 of facilities statewide) worked on quality of care	NFs select one quality of care or quality of life measure from the Minnesota Nursing Home Report Card to improve using their choice of intervention(s). In 2013 (and the most recent QIIP year), 40 NFs (or 11% of facilities statewide) selected resident quality of life		
Minnesota: Value Based Reimbursement (VBR) ^h	3 domains (2017)		Risk-adjusted clinical quality (50%)	Risk-adjusted resident quality of life interviews (40%)		Health department inspections (10%)
Ohio: Nursing Home Quality Incentive System ⁱ	5 measures (2016/2017)	Avoidable inpatient admissions from nursing facilities (20%)	Pressure ulcers - long stay and short stay (20%); antipsychotic use (20%)	Preferences for Everyday Living Inventory or preference survey from MDS (20%)	Employee retention rate (20%)	
Ohio: Enhanced payment for ventilator-dependent residents	2017		Ventilator-associated pneumonia rate (100%)			

State and Program	Total Measures or Domains (Measurement Year)	Categories of Measures or Measurement Domains (portion of total payment for participating facilities attributed to each measure, if known)				
		Utilization	Clinical Care Quality	Resident Experience	Staffing and Staff Experience	Other
Tennessee: QuILTSSⁱ	4 domains; 14 measures (2014)		Clinical performance (10%), including antipsychotic medication (5%), urinary tract infections (5%)	Resident satisfaction (15%); family satisfaction (10%) Culture change/quality of life (30%) including respectful treatment (10%), resident choice (10%), resident and family input (5%), meaningful activities (5%)	Staff satisfaction (10%) Staffing/staff competency (25%), including RN hours per day (5%), CNA hours per day (5%), staff retention (5%), consistent staff assignment (5%), and initial and ongoing staff training (5%)	Facility must meet certain threshold measures to quality for quality payments. Threshold measures include submitting accurate data and timely payments to the pool of funds from which quality payments are drawn. Facilities may also use professional accreditations to earn up to 10% in bonus points to offset performance in other areas.
Texas: QIPP^k	4 measures (2016)	Historical utilization (part of Component 1, worth 10%)	High-risk residents with pressure ulcers; percent of long-stay residents who received an antipsychotic medication; residents experiencing one or more falls with major injury; residents who were physically restrained (part of Components 2 and 3, worth more than 35%)		pressure ulcers; percent of	Submission of a monthly quality assurance performance improvement (QAPI) validation report (part of Component 1, worth 10%)

SOURCES:

^a Arizona Contractors Operation Manual (ACOM). "Arizona Long Term Care System Elderly and Physically Disabled Program Payment Reform Initiative. Chapter 318, CYE16, effective 10/01/2015. Available at <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/318.pdf>. Note that the VBP program involves D-SNP criteria.

^b Arizona Health Care Cost Containment System (AHCCCS). Arizona Long Term Care System (ALTCs) Elderly & Physical Disability (E/PD) Program Contract for Contractors: Solicitation # YH18-0001 ALTCs E/PD. January 2017. Available at https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH18/ReqForProp/ReqForProp_Solicitation.pdf.

^c Long, Charla, Beverly Patnaik, Kathryn O'Day, Nancy Childers, and Kim Chaudoin. "Technical Assistance Report to Bureau of TennCare on the Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative." Nashville, TN: Lipscomb University School of TransformAging, March 2014. Available at: http://www.lipscomb.edu/transformaging/upload/file/64782/tenncare%20report_3.5.14_final2.pdf

^d The Indiana State Department of Health, Long Term Care Division. "Nursing Home Report Cards." Available at: <https://www.in.gov/isdh/reports/QAMIS/ltccr/rptcrd1.htm>

^e Minnesota Department of Human Services. Potential and Active Measures for MSHO Enrollees in Integrated/Coordinated Medicare Medicaid ICSP Subcontract Arrangements. December 2015. Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-286656

^f Minnesota Department of Human Services. "Minnesota Nursing Home Report Card." Available at: <http://nhreportcard.dhs.mn.gov/nhreportcardfactsheet.pdf>

^g Minnesota Department of Human Services. Minnesota Nursing Facility Quality Incentive Payment Program. Summary provided by Teresa Lewis on 1/11/17.

^h Minnesota Department of Human Services. Minnesota Nursing Facility Value-Based Reimbursement System. Summary provided by Teresa Lewis on 1/11/17.

ⁱ "5160-3-58 Nursing facilities (NFs): quality indicators and per Medicaid day quality payment rate." Available at: <http://codes.ohio.gov/oac/5160-3-58v1>

^j TennCare. QuILTSS Nursing Facility Value-Based Purchasing Quality Framework. Available at <https://www.tn.gov/assets/entities/tenncare/attachments/QuiltssFramwork.pdf>.

^k Texas Health and Human Services Commission. "Texas Quality Incentive Payment Program Concept Paper." January 20, 2016. Available at: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/provider-information/qipp-concept-paper.pdf>.

Appendix 2: Summary of Medicaid NF VBP Incentive Approaches

State and Program	Benchmark or Target to Release Payment	Payment Mechanism	Estimated Amount Available for Facilities	Funding Source
Arizona: VBP Initiative ^a	Varies by plan.	Managed care plans must have a portion of total provider payment for LTSS governed by VBP strategies (15% for Medicaid-only contracts and 15% for MA D-SNP contracts in 2016). VBP payments are funded from existing capitation amounts.	Varies based on the arrangement negotiated with the managed care plan.	Quality contribution of 1% of a plan's prospective gross capitation assessed through a reconciliation process.
Arizona: Value-based payment differential	For 2018, NFs that meet or exceed Arizona's average pneumococcal and influenza Medicare Compare vaccination rates receive an increase to existing payment rates.	Managed care plans are required to pass through a 1% increase in payments to NFs that meet the each measure benchmark (2% total possible).	Varies by facility.	Medicaid budget.
Indiana: VBP Initiative ^{b,c}	In the first year, the state distributed the maximum payment to the top 20% of providers, nothing to the bottom 20%, and an amount proportional to score for the remaining 60%. The scores marking each threshold have remained in place, even as scores improve.	One-time increase in per diem rate.	Add-on of up to \$14.30/day in 2010 (~6-8% of the Medicaid daily rate).	Quality assessment fee (provider tax).
Minnesota: ICSP ^d	Varies by MCO.	Varies by managed care plan (generally PMPM or quality bonus; shared savings is less common).	Varies.	Existing capitation payments.
Minnesota: PIPP ^e	The state negotiates improvement targets with each participating facility, establishing a portion of incentive payments at risk for achieving performance targets (up to 20%; downside risk also possible).	One-time add-on to the per diem rate during the project period (1-2 years); recoupments possible following the project.	Up to 5% of the operating payment rate (e.g., a facility with a high-risk PIPP that meets its performance targets could receive and keep an increase of \$10 per day). Facilities can participate in QIIP and PIPP and receive rewards from each program.	State general funds/Medicaid budget and private funds.*
Minnesota: QIIP ^{f,g}	Facilities select one measure to improve, and after 1 year, the state calculates the payment proportional to the amount of improvement over baseline. To receive the maximum payment, facilities must improve by one standard deviation or reach the statewide 25th percentile, whichever represents more improvement.	One-time add on to the per diem rate for the following year.	Maximum award of \$3.50 per resident per day. Facilities can participate in QIIP and PIPP and receive rewards from each program.	State general funds/Medicaid budget and private funds.*
Minnesota: VBR ^h	Adjustments based on a three-part quality score (possible values of 0-100).	Adjustment to the base rate. Rates also contain a hold-harmless provision for facilities, which ensures that their rates do not fall below 12/31/15 levels and that care-related cost limits cannot go down in any year by more than 5% of the median.	If the facility's quality score = 0, its care-related spending limit is 89.375% of the Twin Cities metropolitan median, or \$105.40/resident day for 2017. If its quality score = 100, that limit is 145.625% of the median, or \$171.74. Scores between these endpoints receive pro-rated spending limits.	State general funds/Medicaid budget.

State and Program	Benchmark or Target to Release Payment	Payment Mechanism	Estimated Amount Available for Facilities	Funding Source
Ohio: Nursing Home Quality Incentive System	Facilities must score in or above the 25th percentile for pressure ulcer and antipsychotic medication measures. Avoidable inpatient admission rates must do as well or better than expected. Employee retention must be at or above the 75th percentile. Preferences for Everyday Living Inventory must be used (yes/no).	The state withholds a portion of funding at the beginning of the year (~\$1.79 per member per day), and facilities can earn it back proportionally based on their score on 5 quality measures.	Facilities can earn up to ~ \$2.40 per member per day if they score in the 25th percentile for all 5 measures.	Medicaid budget, direct care rate withhold.
Ohio: Enhanced payment for ventilator-dependent residents	All facilities currently receive \$640 enhanced per diem in lieu of their standard per diem for ventilator dependent individuals. State officials are considering an add-on payment for ventilator weaning.	Adjustment to a NF's base rate. NFs receive an enhanced rate for caring for ventilator depended individuals. A facility may be penalized up to 5% of the enhanced rate if its ventilator-associated pneumonia rate exceeds the state-wide average and it fails to meet a plan of correction.	\$640 enhanced per diem for ventilator-dependent individuals.	State general funds/Medicaid budget.
Tennessee: QuILTSS ^{i,j}	As of 2015 (Phase 1), NFs receive rate adjustments for submitting evidence of activities that build capacity for quality improvement and VBP and/or performance on a limited set of "quality" outcome measures. As of 2016 (Phase 2), facilities must meet threshold measures including accurate data and timely payment of the nursing home assessment.	Phase 1: Quarterly payments for retrospective quality-based per diem rate adjustments. Phase 2: Prospective, per diem rate adjustments.	Current total quality pool is \$31.8 million. The average payment to a facility is \$25,000 per quarter, but payments vary based on the facility's score relative to other facilities and the total days of Medicaid services provided. Some facilities earn as much as 7% in quality-based per diem rate adjustments. Implementation of the new reimbursement structure will raise the quality pool to a minimum of 4% of projected nursing facility expenditures or \$40 million. In the future, up to 10% of rates may reflect quality.	Nursing home assessment fee equal to 4.75% of aggregate net patient service revenue, fees (and percentages) vary by facility size/type.
Texas: QIPP ^k	Payment is based 10% on submission of a monthly quality assurance performance improvement validation report and historical utilization, plus the nonfederal share put up by the hospital district (Component 1); 35% on certain quality indicators (Component 2), and the remainder based on other quality indicators (Component 3). Facilities that meet Component 3 automatically meet the requirements for Component 2. Component 1 is only available to publicly owned facilities, while public facilities and private ones serving >78% Medicaid residents can earn Components 2 and 3. (More information about Components 1-3 is provided in Appendix 1).	Increase in per diem rate based on an increase to the capitation rate. Managed care plans are responsible for releasing the payment each month when the NF meets the metrics.	Varies based on the number of facilities that are eligible and the amount of funds available for distribution. The amount of available funds is capped; as more facilities become eligible, there is the potential for less money per facility.	Intergovernmental transfer contributions and federal match. The total amount of available funds is subject to 1115 budget neutrality requirements and other waiver-funded priorities.

NOTE:

ⁱ Private funds are collected from private paying residents of facilities participating in the PIPP and QIP programs. With a few exceptions, Minnesota's rate equalization law sets private pay daily rates equal to the Medicaid daily rate; therefore, a PIPP or QIP add-on to a facility's Medicaid rate results in an equal add-on to a facility's private pay rate

SOURCES:

^a ACOM 2014 and AHCCCS 2017.

^b Fletcher, Chris and Kris Knerr. "Nursing Home Value-Based Purchasing Operational Issues." Presentation to the Long Term Care Value-Based Purchasing Invitational Meeting, Atlanta, GA, March 11, 2015.

^c Long, Charla, Beverly Patnaik, Kathryn O'Day, Nancy Childers, and Kim Chaudoin. "Technical Assistance Report to Bureau of TennCare on the Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative." Nashville, TN: Lipscomb University School of TransformAging, March 2014. Available at: http://www.lipscomb.edu/transformaging/upload/file/64782/tenncare%20report_3.5.14_final2.pdf.

^d Interview with Gretchen Ulbee and Heather Petermann, Minnesota Department of Human Services, April 14, 2016.

^e Minnesota Department of Human Services. Minnesota Nursing Facility Performance-based Incentive Payment Program. Summary provided by Teresa Lewis on January 1, 2017.

^f Minnesota Department of Human Services. Minnesota Nursing Facility Quality Improvement Incentive Payment Program. Summary provided by Teresa Lewis on January 1, 2017.

^g Held, Robert. "Minnesota Value-Based Purchasing." Presentation to the Long Term Care Value-Based Purchasing Invitational Meeting, Atlanta, GA, March 11, 2015.

^h Minnesota Department of Human Services. Minnesota Nursing Facility Value-Based Reimbursement System. Summary provided by Teresa Lewis on January 1, 2017.

ⁱ Long et al. 2014.

^j Taylor, Jay. "TennCare Long Term Services & Supports (LTSS) Value Based Purchasing." Presentation to the NASUAD HCBS Conference, September 1, 2015.

^k Texas Health and Human Services Commission. "Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program." February 2016. Available at: <https://hhs.texas.gov/reports/2016/02/quality-based-payment-and-delivery-reforms-medicaid-and-childrens-health-insurance-program-rider-46>.

Appendix 3. Mechanisms Other Than VBP That Payers Use to Promote High-Quality Care in Nursing Facilities

To complement VBP, the states and managed care plans interviewed for this brief suggested a number of additional approaches to encourage high quality care in nursing facilities, many of which are currently in use. States that are interested in improving quality in nursing facilities could consider ways to incorporate these strategies into managed care programs or contracts. Alternatively, for strategies that are best designed and managed at the plan level, states might partner with plans to encourage their use.

- **Direct enrollees to preferred facilities.** Several of the states and plans we spoke with emphasized the importance of building relationships between hospitals and nursing facilities. Where close relationships exist, providers work together on improving quality and providing care in the most appropriate setting, for example, through early discharge planning. In Arizona, managed care plans are required to develop strategies that direct enrollees to providers that participate in VBP initiatives and offer value based on measurable outcomes.³⁴ Similarly, Ohio is planning a pilot that would strengthen relationships between hospitals and certain rehabilitation facilities. Under a proposed 1915(b)(4) waiver, four nursing facilities in six counties would divert residents who need more intensive care to inpatient rehabilitation facilities with which they have preferred relationships, rather than send residents to more expensive long-term care hospitals. Hospitals would also develop marketing materials to help encourage patients to select preferred facilities. The managed care plans interviewed also emphasized the importance of developing strong relationships between hospitals and nursing facilities. As one plan explained, “A connection to inpatient care is really important to ensure that residents are sent to an inpatient setting only when care planning has occurred, advanced directives are in place, and families have been offered options for care on site and understand recommendations. Connections also help with continuing conversations about goals of care in the hospital, especially family expectations when the assumption is that hospitals are the place to go for better care.”
- **Promote innovative models of care.** In a qualitative study of reasons for hospitalization from long-term care, limited on-site capacity at the facility to address medical issues was cited as a primary factor driving many hospitalizations.³⁵ To address this, all of the managed care plans interviewed described using models of care that place geriatric clinical care teams (usually led by a nurse practitioner) in facilities (see *Evercare: An Innovative Model of Care*). These teams improve care quality by providing on-site care, medication review, care coordination during transitions to the hospital or community, and education for residents and families. Several plans also provide innovative models of care aimed at certain services types: one plan deploys hospice-trained nurses and social workers to help residents and families conduct care planning, and another brings in local pharmacists who provide onsite flu vaccines. Still another plan encourages its contracted facilities to use the Interventions to Reduce Acute Care Transfers (INTERACT) training model,³⁶ but it does not provide additional financial support to facilities that do so. INTERACT tools, which include medication review with a focus on reducing antipsychotic medications, quality improvement efforts to reduce avoidable hospital admissions, and advance care planning, are also used by most of the facilities participating in CMS’ Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (see *Phase 2 of the CMS Initiative to Reduce Avoidable Nursing Facility Hospitalizations*).³⁷

Evercare: An Innovative Model of Care³⁸

Evercare was a model of care in which nurse practitioners who were employed by managed care companies worked collaboratively with primary care practitioners to deliver a greater level of care to nursing facility residents. Participating nursing facilities received incentive payments for hosting onsite nurse practitioners to offer more intensive primary care services. A CMS-funded demonstration found that Evercare residents were half as likely to be hospitalized as a comparison group of non-Evercare residents. In addition, each nurse practitioner was estimated to save about \$103,000 in hospital costs each year, on average.

Evercare was acquired by United Healthcare, so the name is no longer associated with the care model that was tested. However, the model was a precursor to Institutional SNPs (I-SNPs), and many elements of the model are still used in managed care plans and facilities.³⁹

- **Waive the requirement for three-day inpatient hospital stay to qualify for SNF-level reimbursement.**⁴⁰ FFS Medicare requires a three-day inpatient hospital stay before it will cover a SNF stay, and each resident is limited to up to 100 days of SNF care following the hospital discharge (representing a single spell of illness). This requirement provides a financial incentive for nursing facilities to hospitalize Medicare-Medicaid residents, whose Medicaid-covered long-term stay is reimbursed at a lower rate, because they can receive reimbursement from Medicare at the higher SNF rate after the beneficiary is discharged and returns to the facility. Such hospitalizations can also benefit the state, which is not required to pay for the Medicaid stay while the resident experiences a Medicare-covered hospitalization. During that time, Medicaid is responsible only for resident deductibles and coinsurance for Medicare-covered hospital and SNF services, plus whatever Medicaid bed-hold payments the state may make to the nursing facility.⁴¹

Managed care plans that are responsible for both Medicare and Medicaid costs for individuals who are dually enrolled can reduce or eliminate the financial incentive for nursing facilities to hospitalize patients to obtain the higher Medicare SNF rate by waiving the Medicare three-day inpatient stay requirement for SNF payment.⁴² Plans that waive this requirement pay a SNF rate when it is medically justified, whether or not there is a prior hospitalization, although they may review the medical justification more carefully and frequently than is done in Medicare FFS. As of 2015, 95 percent of non-employer Medicare Advantage plans – including all five plans interviewed for this brief – waive the three-day stay requirement.⁴³

Phase 2 of the CMS Initiative to Reduce Avoidable Nursing Facility Hospitalizations⁴⁴

Improving the capacity of nursing facilities to treat common medical conditions on-site, as appropriate, has the potential to improve residents' care experience and cost less than a hospital admission. In Phase 2 of its Initiative to Reduce Avoidable Nursing Facility Hospitalizations, CMS is testing whether additional payments to facilities for higher-intensity treatment services for medical conditions that might otherwise require hospitalizations can help reduce hospitalizations. Under the initiative, CMS will also increase payment to physicians, nurse practitioners, and physician assistants who provide care onsite to an amount similar to what they would receive for treating beneficiaries in a hospital, and provide additional payments to practitioners who engage in multidisciplinary care planning activities.

- **Consider alternative or supplemental payment strategies.** Though many managed care plans choose to pay nursing facilities using the state prospective per-diem FFS rates and underlying reimbursement methodology, plans – particularly integrated Medicare-Medicaid plans – have the ability to adopt alternative or supplemental payment strategies. States can also encourage plans to adopt alternative payment, for example, through contract requirements. One of the plans interviewed

for this brief (United) is testing an alternative payment model, which pays a bundled rate for specific conditions, in its integrated product (see *A Plan-Initiated Alternative Payment Model for SNF Care*). Another plan interviewed has chosen to provide supplemental payments to cover facility supplies to help avoid service cuts that could impact quality.

- **Increase the use of electronic e-prescribing or certification.** E-prescribing may help reduce medication errors, reduce drug and allergy interactions and therapeutic duplication, and increase prescription accuracy.⁴⁵ In Arizona, managed care plans are required to increase the rate of original prescriptions prescribed electronically.

A Plan-Initiated Alternative Payment Model for SNF Care

In its Medicare Advantage I-SNP product, United Healthcare is testing the option to pay a single, blended rate for high-end therapies, rather than paying based on CMS Resource Utilization Group scores. It also is piloting the use of case rate payments, rather than prospective per diem payments, for short term stay residents. A case rate is a fixed payment based on the average costs for a service or set of services associated with a particular diagnoses or condition. By paying a single case rate, facilities know how much reimbursement they will receive for each case up front, regardless of length of stay or intensity of services provided by the facility. Case rates are intended to encourage efficient care by eliminating the financial incentive for facilities to provide more costly care, or extend a nursing facility stay longer than a resident may need.

- **Share quality measures with facilities, even if they are not linked to payment.** For states or plans that have not yet tied payment to quality measures, encouraging facilities to become familiar with quality measurement can be an important first step. One plan interviewed for this brief reported that its state-sponsored VBP initiatives have enabled facilities to become very experienced in gathering and reporting data outside of what is required by Medicare, and in understanding how payment methodologies play out in real time. Another plan interviewed that has not yet tied payment to quality measures has begun to provide facilities a set of HEDIS and state-required pay for performance measures for all newly admitted residents, including those that have not had a flu shot, in order to introduce measurement concepts. The plan also meets regularly with each facility to discuss the measures and the ways in which they impact care.

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the **Integrated Care Resource Center** are coordinated by **Mathematica Policy Research** and the **Center for Health Care Strategies**. For more information, visit www.integratedcareresourcecenter.com.

ENDNOTES

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- ¹⁵ CMS' Nursing Home Compare consists of quality measures only; the Nursing Home Compare Five-Star Quality Rating System adds facility inspection results and staffing data to the quality measures to produce ratings of overall performance.
- ¹⁶ "Benchmark" implies a minimum threshold that a facility would have to meet to receive a payment, established based on pre-existing measurement experience from other facilities. "Target" implies a broader range of values a facility would need to meet, and those values are not necessarily based on experience. This brief uses the term target to refer generally to benchmarks or targets that a facility must meet to receive the reward.
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- ²⁰ CASPER compiles all data elements collected during the inspections that certify nursing facilities to participate in the Medicare and Medicaid programs. CASPER data is maintained by CMS in cooperation with state long-term care surveying agencies. CASPER and the Quality Improvement Evaluation System (QIES) replaced the Online Survey Certification and Reporting (OSCAR) system in July 2012. For more information, see: <http://www.longtermcareinfo.com/data/casper-and-oscar.php>.
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