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# Real World Strategies for Successful VBP Programs

# Today's Presenter

## Janine Savage

VP of Product Management,  
Analytics & Post-Acute



### Predictive Analytics and Value-Based Care: Analytics in Practice

🏠 > Blog > Predictive Analytics and Value-Based Care: Analytics in Practice

### Predictive Analytics and Value-Based Care: Tackling Triple Aim

By J  
VP,

🏠 > Blog > Predictive Analytics and Value-Based Care: Tackling Triple Aim

### Predictive Analytics and Value-Based Care: Defining Value

🏠 > Blog > Predictive Analytics and Value-Based Care: Defining Value

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By Janine Savage, RN, CHC

*VP, Product Management, Analytics & Business Intelligence*

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*Benefits to SNFs, their partners and the healthcare continuum*

Check out Janine's most recent analytics blogs at [pointright.com](https://pointright.com)

# Objectives



Discuss why value-based care is timely and necessary



Understand the factors that make a VBP program successful



Leverage lessons learned from a successful VBP program

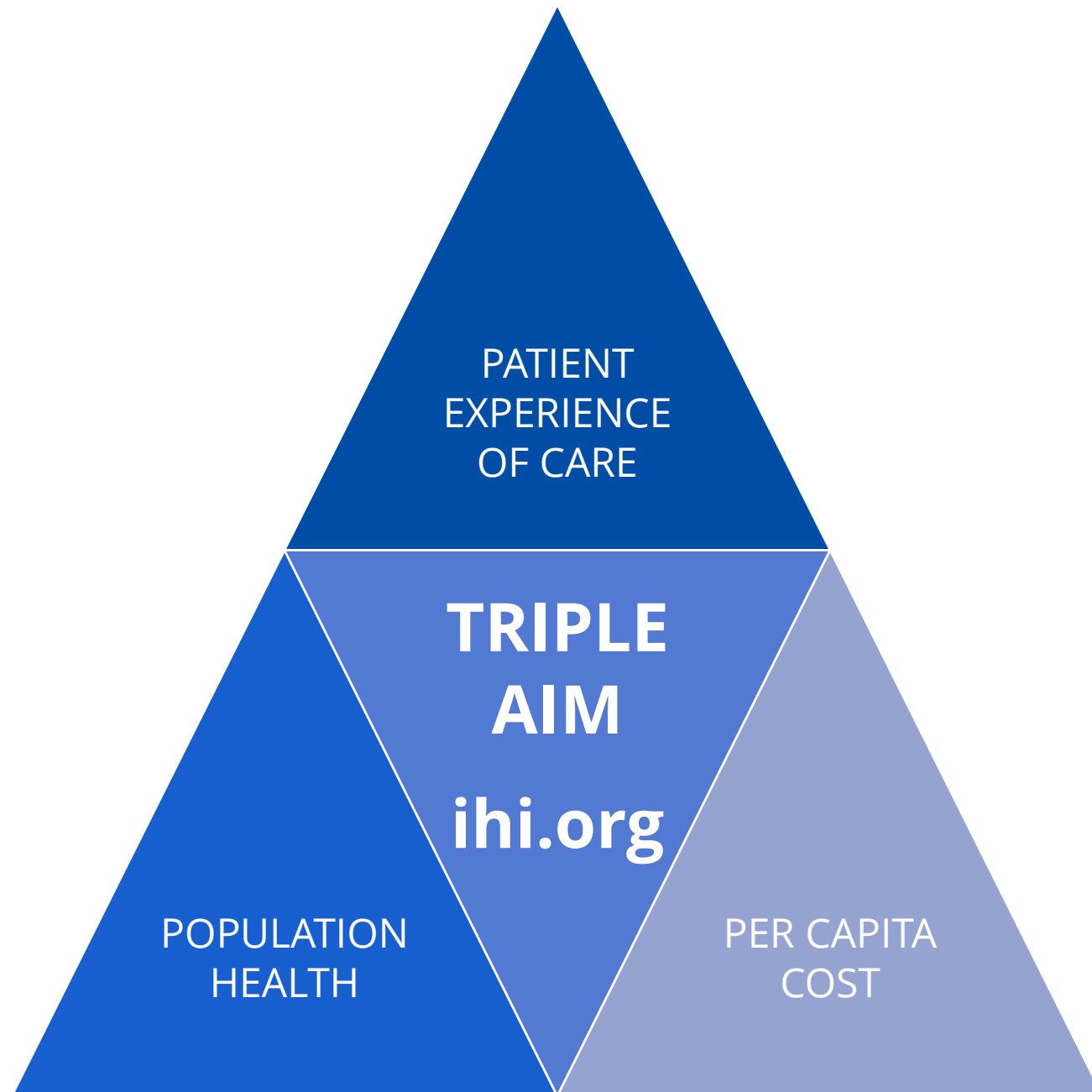
# Why Value Based Payment Programs for Nursing Facilities?



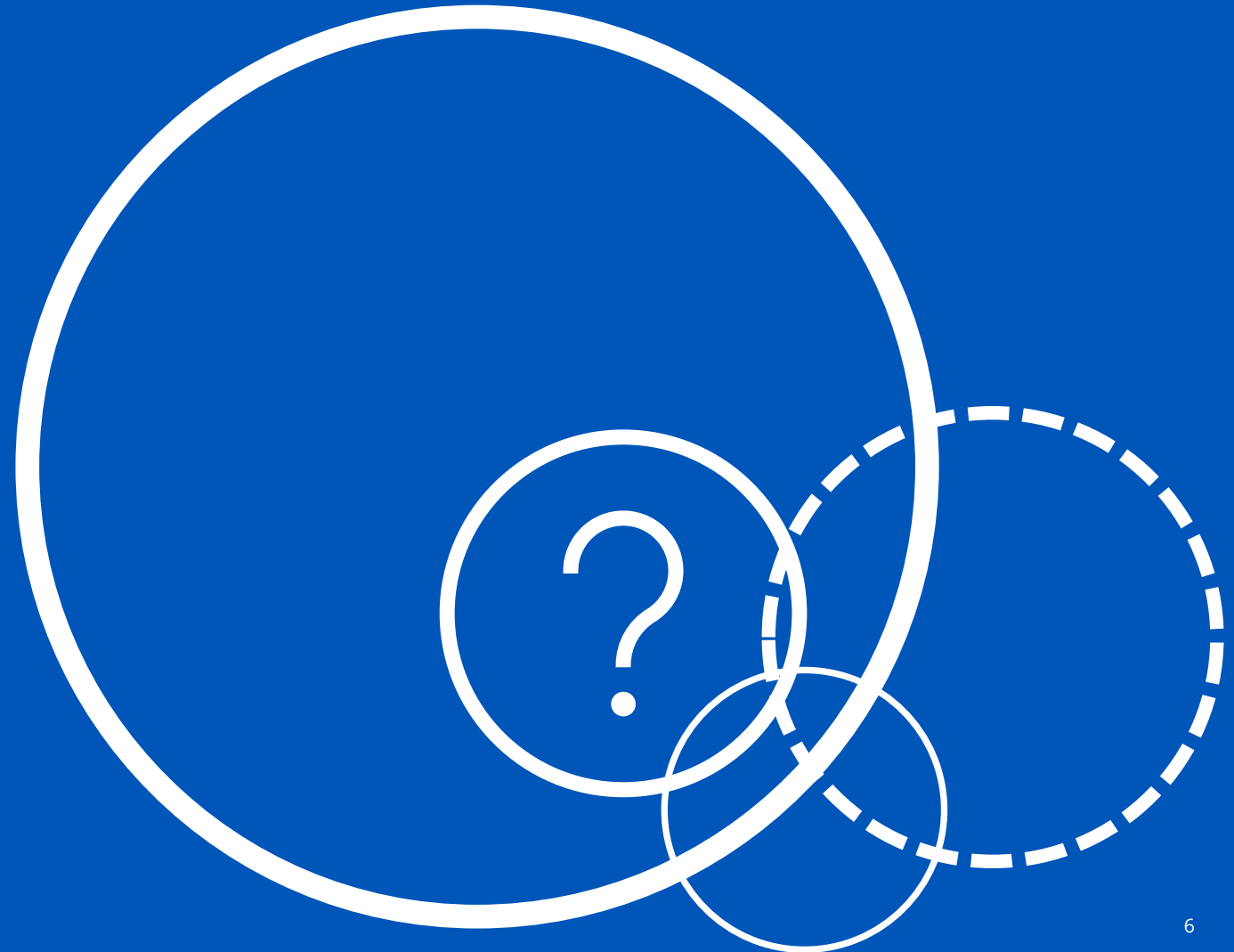
- Achieve the goals of accountable care
  - Drive quality
  - Improve care coordination
  - Reduce care cost
- Align with CMS Innovation Strategy “refresh”
- Successful models already exist



Figure 1. CMS Innovation Center Vision and 5 Strategic Objectives for Advancing System Transformation.

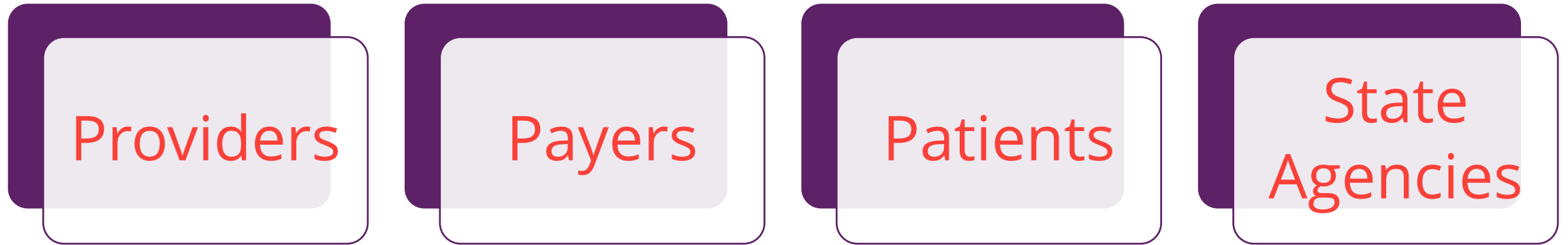


# Stakeholder Engagement





# Who are the stakeholders?



**NM stakeholders:** Four-pronged approach consisting of a Community Advisory Board (CAB), Managed Care Organization (MCO) VBP workgroup, Provider Advisory Group (PAG) and Project ECHO

# What are the goals and objectives?

- Specific clinical & quality outcomes
- Incidence of adverse events
- Utilization outcomes
- Change in process
- Adoption of new technologies
- Other outcomes or results



**NM project goals:** improve quality of care, reduce avoidable hospitalizations, and optimize health for all New Mexico Medicaid members receiving services in nursing facilities by 2023

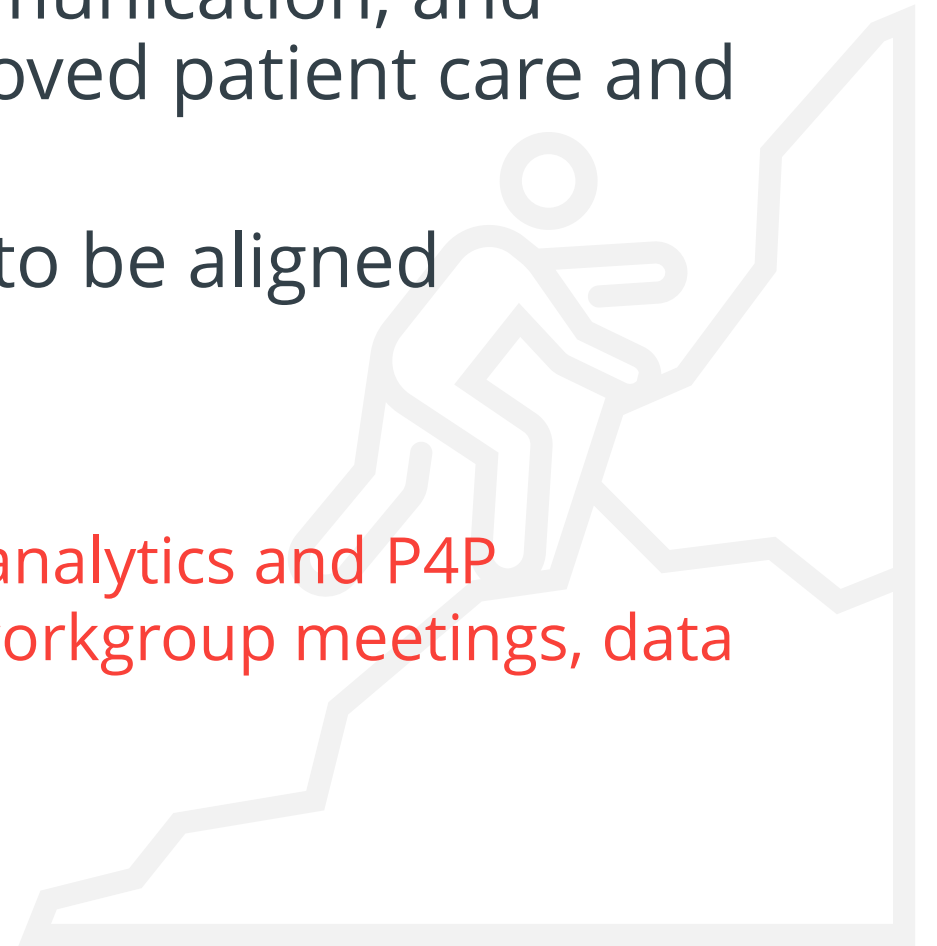


# What can be achieved?



- Success through partnership and collaboration
- Properly leveraged data/analytics, communication, and transparency can effectively drive improved patient care and better patient outcomes
- Program design and deliverables need to be aligned accordingly

**NM key factors:** access to same patient-level analytics and P4P  
Dashboard for providers and payers, regular workgroup meetings, data analytics vendor as a partner & facilitator



# The Right Mix of Incentives & Penalties

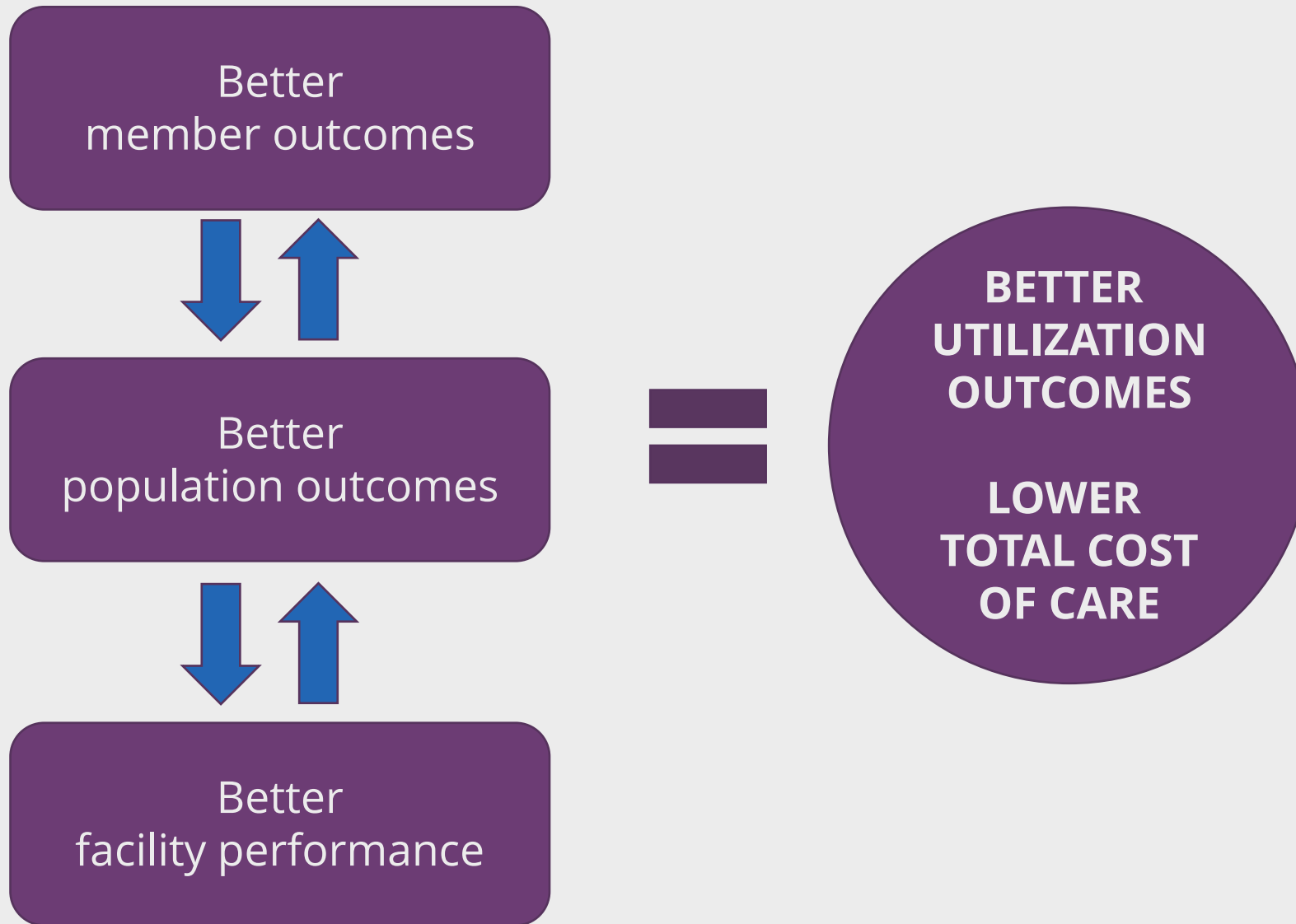


*“Value-based payments are a tremendous opportunity for us to better care for our state’s most vulnerable residents. But we needed to get all parties working together using the right incentives and penalties to transform our payments system and create a system that would be both effective and long-lasting.”*

Dr. David Scrase, New Mexico’s Cabinet Secretary for Health and Human Services



# Benefits for the ACO/Payer



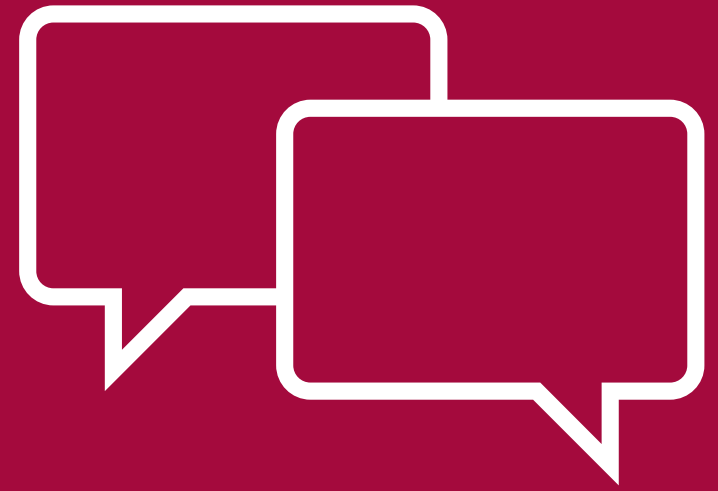
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**PointRight**  
A Net Health Company

“The PointRight products give us the access we need to monitor and track much needed quality information from the nursing facilities.”

*Monica Marthell  
Manager, Value Based Payment Initiatives  
Western Sky Community Care*

# Effective Design, Quality Measurement & Payment Structure





COMPONENTS  
OF A  
VBP  
QUALITY  
PROGRAM

Funding mechanism

Quality measurement

Assessing performance

Linking performance to payment

# Funding Mechanism



Payer funded

State allocated funds

Provider surcharge/tax

Federal matching funds

# Quality Measurement

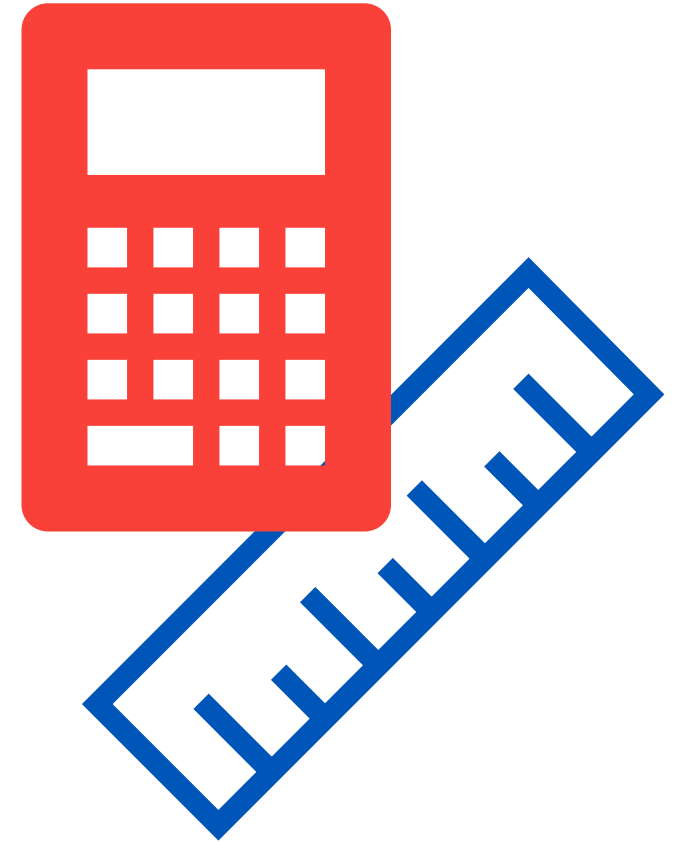


- **Measure selection**

- Measure types (structure, process, outcome, and resource utilization)
- Patient populations (short-stay, long-stay)
- State and provider priorities
- Current and historical performance
- Validity and reliability

- **Calculation methodology**

- Real-time or measures already calculated/reported?
- Are specifications available?
- What data is needed?



# Assessing Performance

case mix adjustment



quintiles

**benchmarks**

points

quartiles

**rates**

**achievement**

improvement

**ranking**

**baselines**

achievement

**tiers**

baselines

**case mix adjustment**

rates

**quartiles**

benchmarks

**points**

tiers

**improvement**

**quintiles**

ranking



# Example: Targets, Points, and Tiers



QM	20	40	60	80	100
<b>Measure #1</b>	23.9% - 100%	17.3% - 23.89%	12.7% - 17.29%	6.8% - 12.69%	0.0% - 6.79%
<b>Measure #2</b>	4.53% - 100%	2.73% - 4.52%	1.61% - 2.72%	0.71% - 1.60%	0.0% - 0.70%
<b>Measure #3</b>	8.6% - 100%	6.1% - 8.59%	4.4% - 6.09%	2.6% - 4.39%	0.0% - 2.59%
<b>Measure #4</b>	15.01% - 100%	12.01% - 15.0%	9.1% - 12.0%	6.1% - 9.0%	0.0% - 6.09%

<b>Tier 1</b>	260 points or more
<b>Tier 2</b>	200 to 259 points
<b>Tier 3</b>	140 to 199 points
<b>Tier 4</b>	100 to 139 points
<b>Tier 5</b>	99 points or less

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
<b>1<sup>st</sup> year</b>	100%	85%	75%	50%	20%
<b>2<sup>nd</sup> year</b>	100%	80%	60%	40%	10%
<b>3<sup>rd</sup> year</b>	100%	75%	50%	25%	0%



## Foundational Payment

- To encourage participation and help offset any costs to the facilities for participating in the program (data submission, etc.)
- Set amount for the performance period
- May be adjusted for quality performance

## Quality Payment

- Based on quality measure performance
- Each facility is eligible to receive the maximum amount available
- An adjustment is applied based on quality measure performance level
- Amount of payment is determined by bed days as a multiplier

## Reallocation/Residual Funds Payment

- Methodology for redistributing funds remaining (quality payment pool minus total amount paid to facilities after adjustment is applied)
- May also be adjusted for quality performance outcomes

## Secondary Payment

- Additional payment based on different criteria (residents with high-acuity conditions, additional quality measures, etc.)
- To encourage facilities to participate in certain programs or adopt certain behaviors

# Linking Performance to Payment: Payment Mechanics

## Other Program Considerations

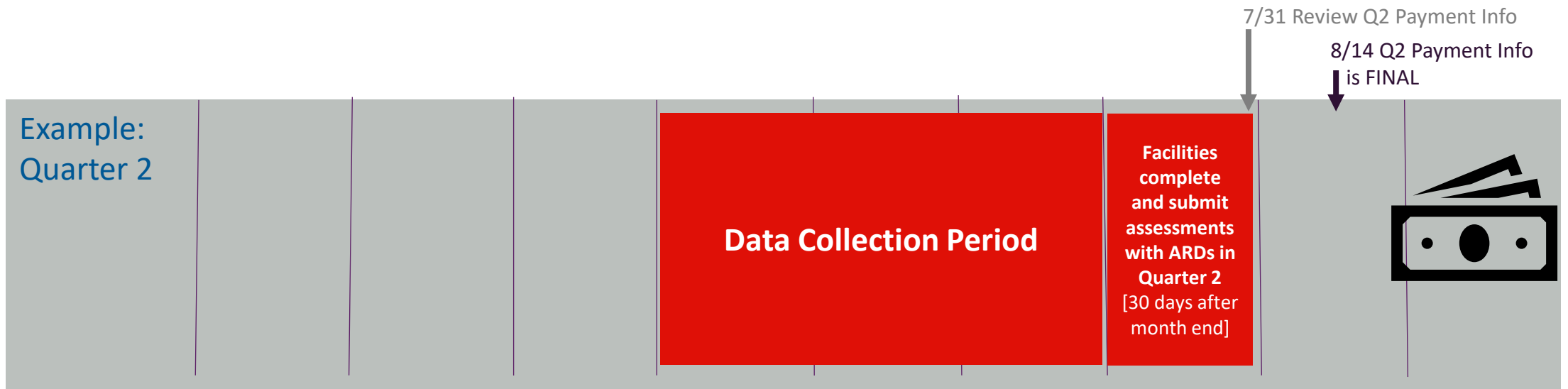
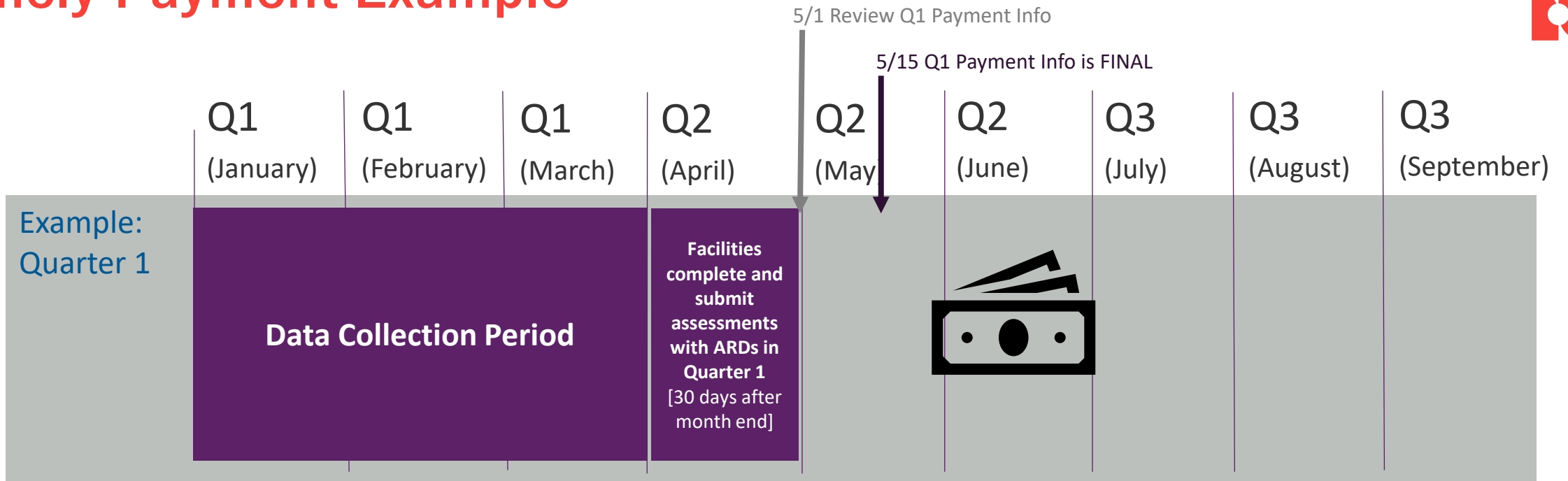
- Facility participation requirements and consequences for not meeting them:
  - Eligibility and enrollment
  - Data submission
  - Contractual requirements
- Transition period?
- Time frame for each performance period and payment



**NM considerations:** initial “ramp up” pay for reporting, then pay for performance; 12-month performance period with quarterly outcomes measurement and payment



# Timely Payment Example



# Data & Analytics



# Analytics for Measure Selection



- A broad set of measures creates incentive to perform well across the board, rather than focus narrowly on a small number of areas and avoid “teaching to the test”
- Handling of bias
- Accounting for clustering, variable sample sizes and geolocation
- Data analysis across time
- Accounting for random versus systematic variation (e.g., impact of COVID-19 on measures)
- Performance metrics that incorporate the best possible information as to performance in comparison to outcomes that would be expected if the same patients were to receive care that matched the comparative norm
- Risk adjustment
- Imputation rules

# Data Collection

- Standardized datasets:
  - Clinical/MDS
  - Claims/UB-04 (837I)
- LTPAC EHR data is not standardized
- CMS publicly reported measures
- Standards for data exchange
- Data exchange realistic possibilities

**NM requirements:** minimize data collection and submission burden for facilities and ensure it fits into their existing workflow and ensure data source that allows for real-time actions to be taken



# Delivery of Analytics



- **Relevant, timely, and actionable** to help providers achieve payment incentive targets and execute data-driven performance improvement
- Fit easily into **existing workflow**
- **Simple-to-understand** insights

**NM requirements:** show actual facility performance in past time periods, forecasted facility performance for current time period, and real-time information at patient level; highly-intuitive user experience in a dashboard format with export capabilities



# Design Examples



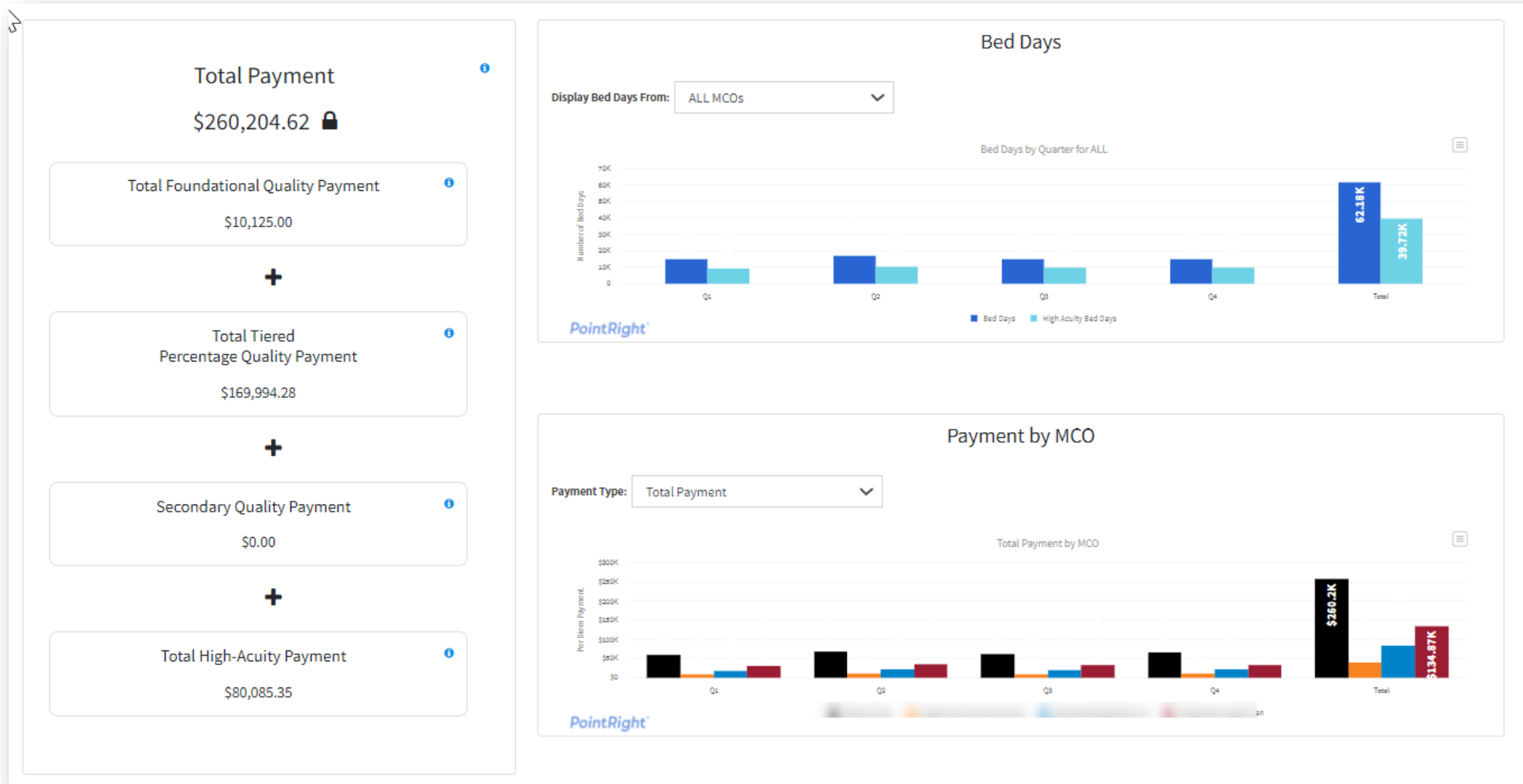
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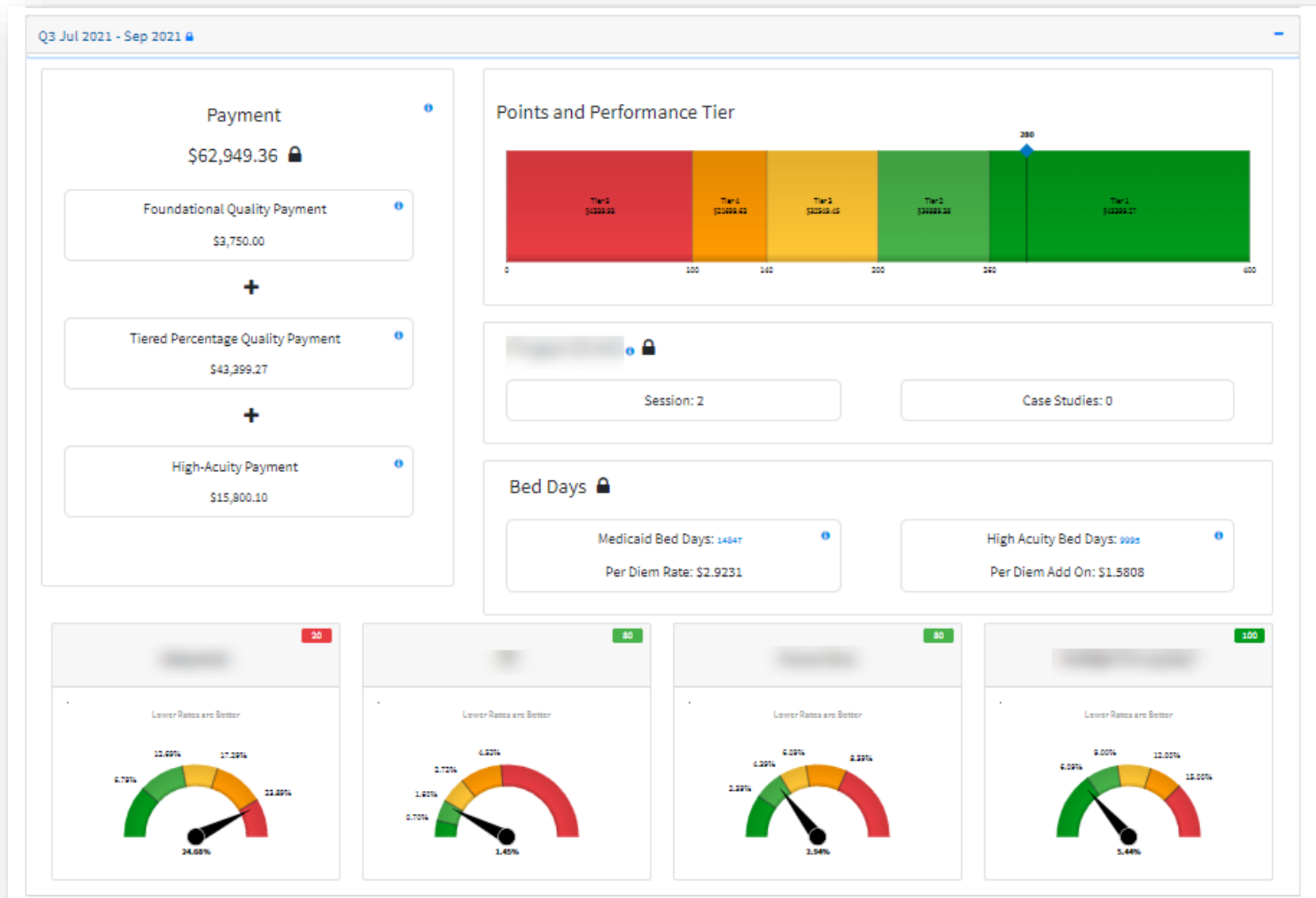
**Their software tools are easy to use with meaningful data and analytics—both at aggregate level and down to the facility and member level.”**

*Tim Voskuil  
Performance and Results Consultant  
Network Services  
Blue Cross and Blue Shield of New Mexico*

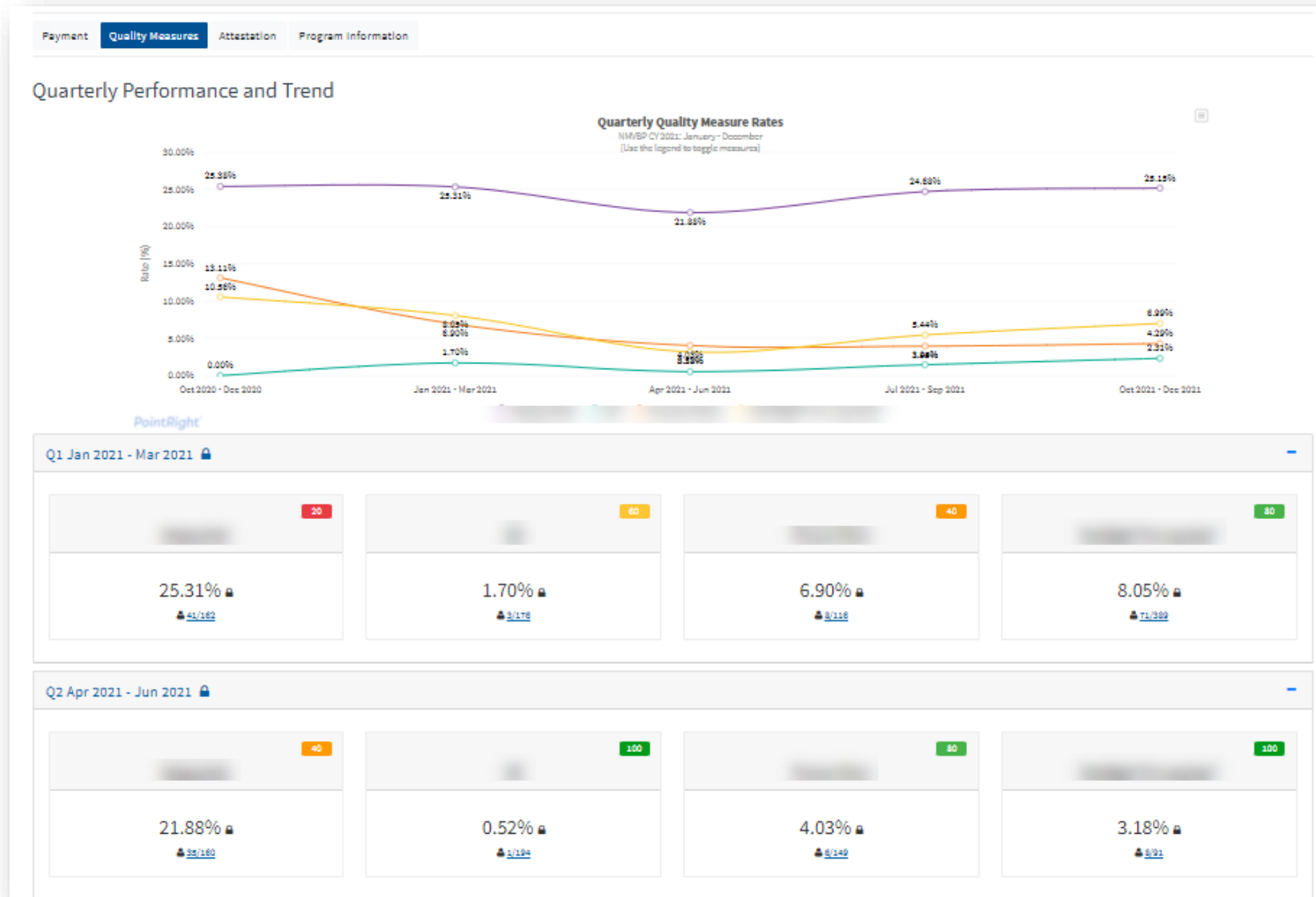
# Payment Information



# Payment Information



# Quality Measures: Facility



# Quality Measures: Patient/Member



Q 1
Q 2
Q 3
Q 4

20

25.31%

41/162

### Targets

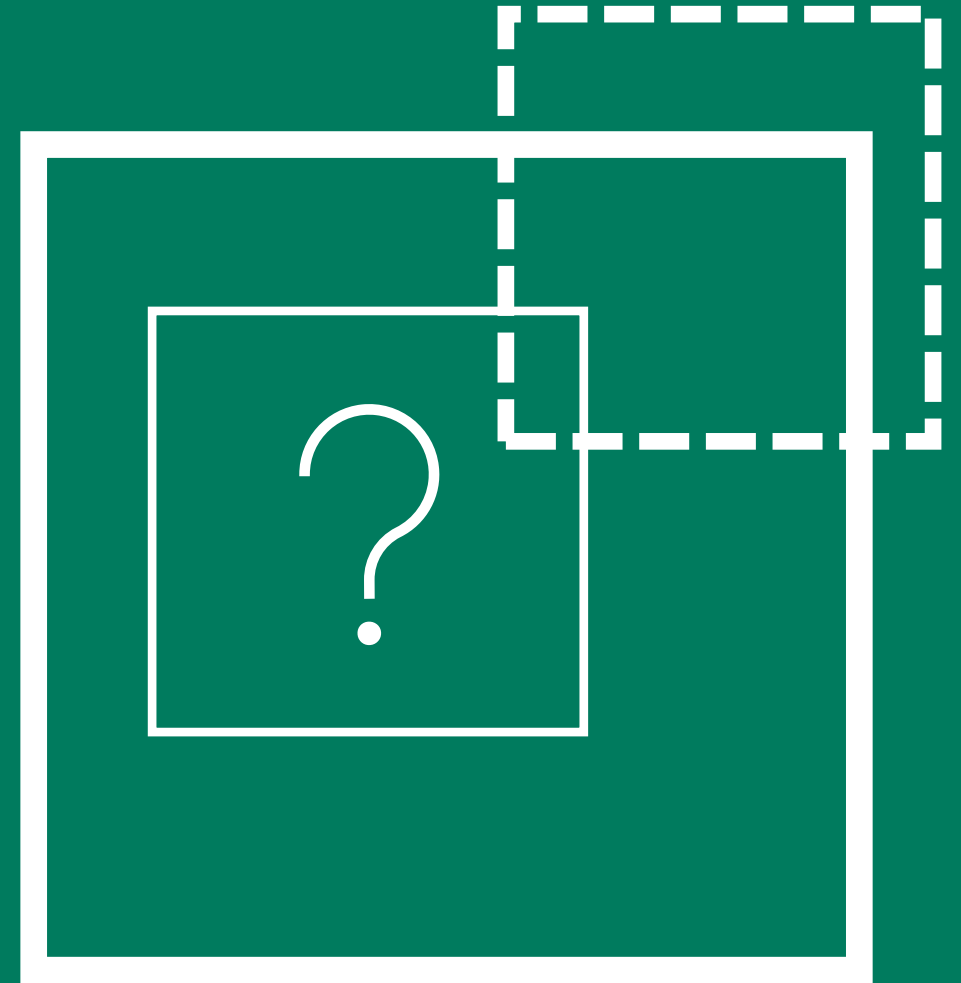
	Target Rate	Residents Needed to Achieve
Tier 1	6.79%	31 fewer
Tier 2	12.69%	21 fewer
Tier 3	17.29%	13 fewer
Tier 4	23.89%	3 fewer

### Resident List

Display:
 Residents who triggered for the QM
  Residents in the denominator who did not trigger for the QM

Name	DOB	MRN	Room	ARD
[blurred]	[blurred]	[blurred]	322	03/12/2021
[blurred]	[blurred]	[blurred]	214	03/12/2021
[blurred]	[blurred]	[blurred]	314	01/17/2021
[blurred]	[blurred]	[blurred]	211	03/03/2021
[blurred]	[blurred]	[blurred]	420	01/10/2021
[blurred]	[blurred]	[blurred]	501	12/29/2020
[blurred]	[blurred]	[blurred]	317	03/16/2021
[blurred]	[blurred]	[blurred]	710	01/26/2021
[blurred]	[blurred]	[blurred]	416	03/09/2021

# Implementation & Ongoing Evaluation



# Implementation & Support



- Gold standard implementation process
- Education and training
- Best practice sharing
- Office hours with experts
- Accessible program information and FAQs in-app

**NM requirements:** help providers achieve payment incentive targets and execute data-driven performance improvement in quality measures; help determine future program targets and requirements; help state meet CMS approval requirements

**New Mexico Nursing Facility Value Based Purchasing Program**

The Nursing Facility Value Based Purchasing Program project includes a four-pronged approach consisting of a Community Advisory Board (CAB), MCO VBP workgroup, Provider Advisory Group (PAG) and Project ECHO. The project goals are to improve quality of care, reduce avoidable hospitalizations, and optimize health for all New Mexico Medicaid members receiving services in nursing facilities by 2023.

- The program has four components:
  - Funding mechanism
  - Measure selection
  - Assessing performance on measures
  - Linking performance to payment

**Eligibility**

- To be eligible for the program, the nursing facility must meet the following minimum requirements:
  - Certified Medicaid facility
  - Contracted with at least one Medicaid Managed Care Organization (MCO)
  - Data use agreement signed with data intermediary (PointRight) and MCO
  - Submit MDS data to PointRight, the data intermediary
  - Have the minimum amount of Medicaid bed days
- Within six months of implementation, the nursing facility must meet the following requirements. Failure to do so within the stated timeframe will result in suspension of Foundational Payments until requirements are met.
  - Participate in required number of Medicaid Quality Improvement and Hospitalization Avoidance (MQHA) Project ECHO sessions
  - Data use agreement signed with Collective Medical Technologies (CMT) for Post-Acute Edie
  - Participate in Post-Acute Edie Emergency Department Information Exchange
  - Have 200M capabilities to participate in Project ECHO

**Q. Are MDS modifications and corrections used to calculate Medicaid bed days?**

A. A correction of an MDS assessment (i.e. inactivation or modification) will only be used if the ARD of the assessment being corrected falls within the open data collection period and the correction is submitted to PointRight during the open data collection period or within 30 days following the end of the open data collection period.

**Q. Are retroactive Medicaid eligibility changes considered in the calculation of Medicaid bed days?**

A. The data collection period is closed 30 days after the last day of the quarter. Retroactive eligibility changes contained in a member en...

**Q. What counts as a High-Acuity Medicaid Bed Day?**

A. If the MDS indicates that a resident has one of the following conditions, then that resident's Medicaid bed days are considered High-A...

- ALS (MDS I8000 = G12.21)
- Levy-Body Dementia (MDS I8000 = G31.83)
- Dementia with behavioral disturbance (MDS I8000 = F02.81 or F03.91)
- Cerebral palsy (MDS I4400 is checked)
- Multiple sclerosis (MDS I5300 is checked)
- Huntington's disease (MDS I5350 is checked)
- Parkinson's disease (MDS I5300 is checked)
- Tourette's syndrome (MDS I5350 is checked)
- Traumatic brain injury (MDS I5500 is checked)
- Bipolar disorder (MDS I5900 is checked)
- Schizophrenia (MDS I5950 is checked)
- Psychotic disorder other than schizophrenia (MDS I6000 is checked)
- Post-traumatic stress disorder (MDS I6200 is checked)

**Q. Why don't I have any Secondary Payment amount?**

A. The Secondary Payment is a yearly payment calculated at the end of the calendar year performance period, after quarter four ends. In order to be eligible for a Secondary Payment in the 2019-2020 performance period, the facility must have at least four (4) telemedicine visits in the calendar year. The number of telemedicine visits must be entered on the Telemedicine tab each quarter by a user who has "edit" permission for this tab. (To find out who has edit permission for this tab, contact PointRight support.)

**Q. I submitted an MDS today with an ARD in the current quarter that triggers a QM, so why don't I see the resident's information on the QM details page?**

A. The NMVBP product is refreshed once daily. Applicable data from an MDS assessment should be included in the PAP Dashboard information the day after it is submitted to PointRight.

**Q. Why is there a red flag in the "Flags" column on the Bed Days Analysis page?**

A. The red flag appears when there is an MDS assessment that is overdue. This could be for one of the following reasons: 1) there are more than 100 days since the last MDS record; 2) the resident was found to have entered another facility since the last assessment and there is no Discharge assessment; or 3) there are more than 92 days between an OBRA assessment and the previous OBRA assessment (Quarterly or Comprehensive). To determine the reason, review the resident's MDS History (click on the resident's name).

**Q. On the Quality Measures tab in the quarter section, why does "IMPUTED" appear at the top left of a measure?**

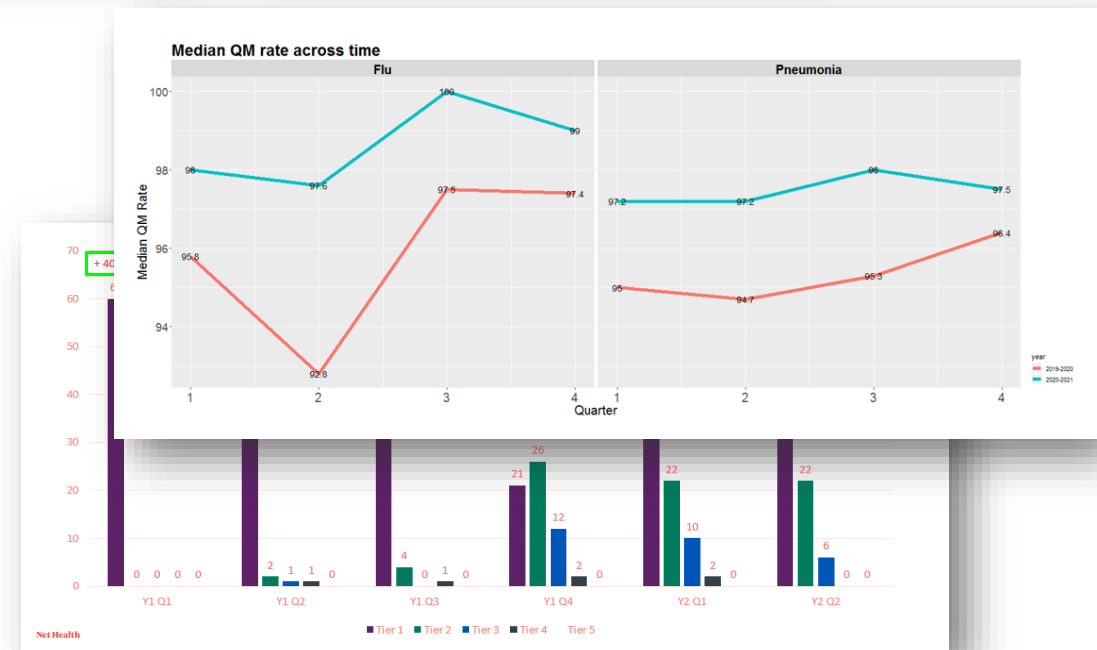
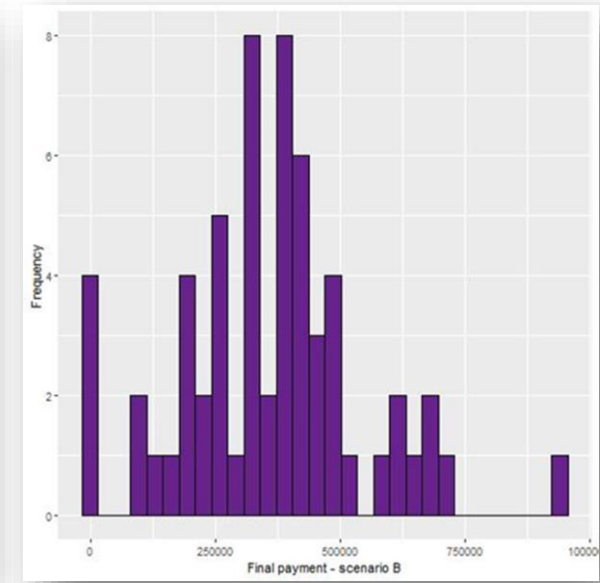
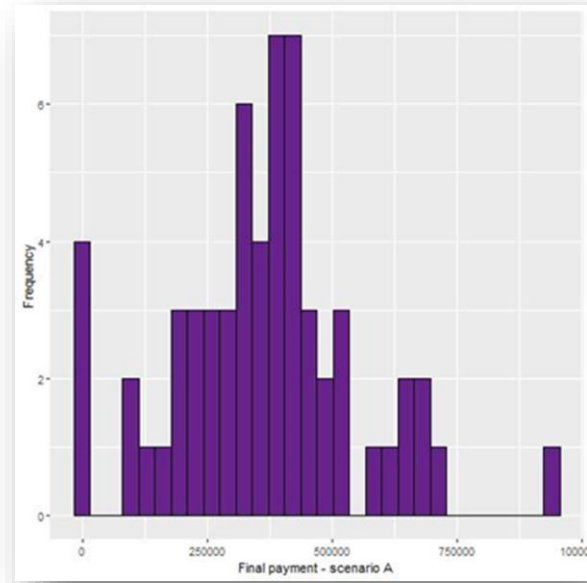
A. In the instance where a specific QM cannot be calculated for a facility (e.g. not enough instances in the denominator), the facility is assumed to perform at the state average for that QM. Therefore, the measure is labeled as "imputed."

**FREQUENTLY ASKED QUESTIONS**

# Ongoing evaluation

- Performance evaluation
- Statistical significance
- Impacts
- Outliers
- Baselines
- Benchmarks
- “What if” scenarios
- Recommended adjustments and changes

**NM requirements:** help determine future program targets and requirements; provide information for state to fulfill CMS approval requirements

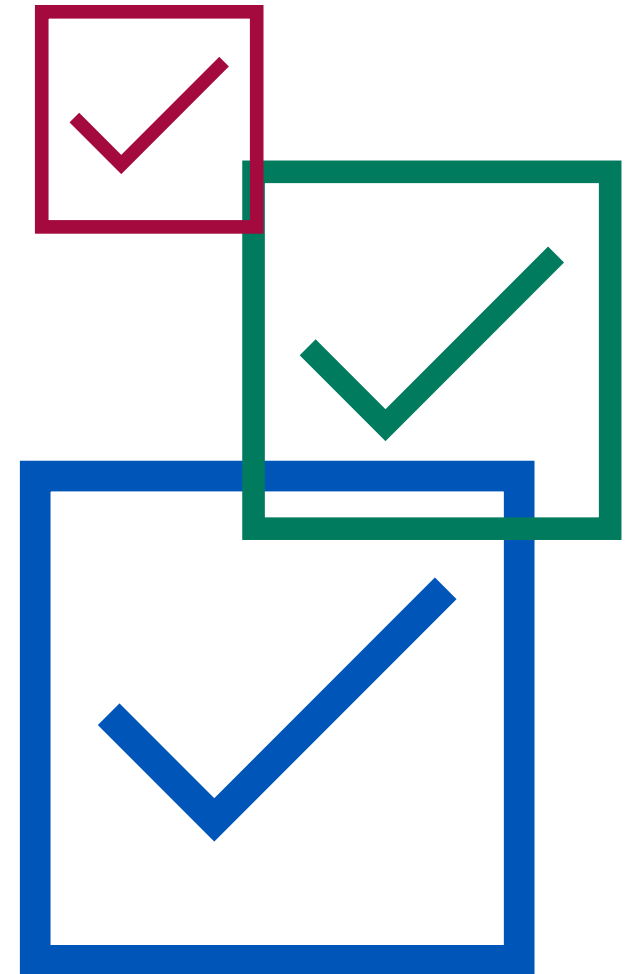




# Recreate Success



- Learn from those who have blazed the trail  
Case study:  
[New Mexico Nursing Facility Value Based Payment \(NF VBP\) Workgroup Partners with PointRight® to Improve Patient Care and Outcomes](#)
- Choose the right partner:
  - Industry subject matter expertise
  - Deep knowledge of provider and payer needs
  - Analytics & data science core competencies
  - Proven success at scale



# Q&A



# Stop by our VBCExhibitHall.com Virtual Booth



PointRight can be found in the  
[Population Health II: Software Tools & Data Analytics Exhibit Hall](#)

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# Thank you!

Questions?

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