

NURSING FACILITY VALUE BASED PURCHASING FAQs

PERFORMANCE & PAYMENT-RELATED FAQs

QUESTION	RESPONSE
How will the program deal with measuring attainment for a facility with less than 12 months participation in Medicaid – and/or less than 12 months of data due to a facility being considered new to CMS – in a performance year?	A new facility – whether new to Medicaid or new to CMS – would become eligible to participate in the program for attainment funds with as little as one full quarter of participation in the VA Medicaid program, at the Commonwealth’s discretion and subject to measure data availability. DMAS will ‘annualize’ quarters with performance data for these facilities, and reserves the right to adjust award amounts to align with partial year participation.
Scenario: Facility ABC has complete Quarter 1 data with CMS; however they joined Medicaid in February. How will DMAS handle the data for Facility ABC?	Because Facility ABC has a complete quarter of data with CMS, DMAS will use the complete quarter of data as part of the performance calculation. However, DMAS will use the actual, calculated Medicaid days for this facility to adjust the payment volume if they attain within a certain threshold.
How will the program handle missing data in cases other than the facility being new to CMS and/or Medicaid?	As a rule, DMAS will base measure results on data that are available. For most measures, DMAS’ measure result will align exactly with the result reported by CMS. For the Total Nurse Staffing Hours per resident day (case-mix adjusted) measure, DMAS will weight available quarters’ results by their respective Medicaid days and divide that result by four. As such, DMAS encourages facilities to review the publically posted CMS data to confirm accuracy prior to DMAS calculating facility program performance and performance payments, thereby ensuring optimal payment amounts.
How will the program deal with measuring improvement for a new facility that does not have previous performance data?	New facilities without previous performance are not eligible for an improvement payment in their first program year as there is no previous performance data for comparison. The first performance year would become the baseline line for the next program year’s improvement analysis.
If a facility has less than 12 months of participation in Medicaid during their first performance year, how will improvement be determined in the second program year?	The facility would be ineligible to earn improvement funds until their second year of program participation. The facility’s first year of attainment – be it a full or weighted performance – shall be used as the basis upon which their subsequent performance year’s improvement is measured.
How will the incomplete Q4 Medicaid Days’ data be handled?	<p>Due to the steps required to validate MCO Medicaid encounters by both DMAS and its vendor partners, the 4th quarter Medicaid days’ data of a given performance period are still being processed by the time payment 1 performance data is available. To address the incomplete fourth quarter NF days while still distributing funds to NFs responsively, for Program Years 1 and 2, the NF VBP program generates a proxy quarter Medicaid days’ value for each Federal Provider Number (FPN) based on an average of the Medicaid days of the first three quarters’ performance year across data sources (i.e., Medicaid fee-for-service or managed care) and program (i.e., Commonwealth Coordinated Care Plus). The total Performance Year Medicaid Member days for each FPN is the sum of the first three quarters of Medicaid days’ data and the proxy quarter Medicaid days’ value, as follows:</p> $Q1days + Q2days + Q3days + \left(\frac{Q1days + Q2days + Q3days}{3} \right)$ <p>DMAS will monitor the degree to which 4th quarter actual days align with proxy days and consider future methodological changes, if necessary.</p>
If a facility has less than 12 months of participation in Medicaid during their first performance year, how will the 8 HR RN measure thresholds and improvement be assessed in the next full performance year?	The program will annualize their performance from the available data in the facility’s first performance year by weighting the available full quarters of available data to generate a yearly estimate to measure improvement in the second year

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When are Medicaid days used for per diem calculations considered final?	<p>The program will use the most current measure data reported, as of:</p> <ul style="list-style-type: none"> • Four months post the NF VBP performance year for the Staffing, UTI, and Pressure Ulcer measures. • Seven months post the NF VBP performance year for the ED Visits and Hospitalizations measures. • Note: once measure data is used for payment of Attainment funds in a performance year, that period's measure data will be considered final even if CMS releases updated measure data for that period, as that period's final measure values represent the improvement baseline for the following year. DMAS may reserve the right to make exceptions to this policy in instances where measure data (e.g. updates are the result of systemic issues impacting facilities across the program)
What is the difference between how the Nursing Home Compare RN star rating is calculated and the NF VBP 8 HR RN measure is calculated?	The NF VBP 8 HR RN measure annualizes the quarterly requirements to build more flexibility into the measure for facilities.

TRANSFER OF OWNERSHIP-RELATED FAQs

<p>If a facility(s) has transferred ownership during a measurement period, and it is determined the facility(s) will be awarded a payment based on its performance, does the previous owner or the new owner receive payment?</p>	<p>Payment is to be made to the owner/operator of the NF at the time of payment - regardless of who had ownership during the relevant measurement period. DMAS/MCOs attempt to remit payments to the most current owner/operator of a NF based on available information at the time of payment. However, if payments are erroneously made to a previous NF owner/operator who is no longer the owner/operator at the time of payment, DMAS/MCOs will recoup those funds and attribute payment to the current owner after receiving, from the current owner/operator, proof of their ownership at the time payment was made. Proof of ownership date can be established by:</p> <ul style="list-style-type: none"> • Ownership on the payment date as documented in DMAS' "Reimbursement Rates" section of DMAS' "Nursing Facilities" webpage Nursing Facilities DMAS - Department of Medical Assistance Services (virginia.gov), which provides regularly updated information on changes in ownership and their effective dates. • Other sources of information establishing proof of ownership date (e.g., CMS NPPES NPI registry). <p>Once proof of ownership is successfully established, the DMAS/MCO will follow respective internal protocols for recoupment of funds from the previous owner/remittance of funds to the current owner.</p> <p>Under exceptional circumstances, DMAS/MCOs may consider omitting the step of recouping funds erroneously made to a previous NF owner/operator if both new and old owners can provide documentation (e.g., a signed attestation) that both parties are in agreement with payment being made to the previous owner/operator. DMAS/MCOs will make the final determination about whether to grant such exceptions on a case-by-case basis.</p>
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