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Building a Strong Long-Term Care Workforce

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Linking Payment to Long-Term Care Quality: Can Direct Care Staffing Measures Build the Foundation?

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LINKING PAYMENT TO LONG-TERM CARE QUALITY: CAN DIRECT CARE STAFFING MEASURES BUILD THE FOUNDATION?

By
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April 2005

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LINKING PAYMENT TO LONG-TERM CARE QUALITY: CAN DIRECT CARE STAFFING MEASURES BUILD THE FOUNDATION?

TABLE OF CONTENTS

FIGURES

LINKING PAYMENT TO LONG-TERM CARE QUALITY: CAN DIRECT CARE STAFFING MEASURES BUILD THE FOUNDATION?

EXECUTIVE SUMMARY

To improve long-term care quality, state and federal policymakers are experimenting with positive incentives to reward providers who can demonstrate better quality. Incentives may consist of either financial payments or non-financial recognition. This paper describes the challenges involved in designing effective quality incentive payment systems in the long-term care sector.

Incentive payment systems are part of a broader trend in the health care field, referred to as "pay-for-performance", which ties provider reimbursement to achievement of better patient health outcomes. The long-term care sector is better positioned to track patient outcomes than acute and primary care providers because federal law has required nursing homes to report measures of patient health and functioning since 1991, and home health agencies since 1997. These measures are used to develop quality indicators in public reporting systems and to help organizations identify internal quality issues. Data on patient's health and functional status are also used to develop prospective payment rates. But this data has not been used to reward providers that produce better patient outcomes due to concerns about the measures' validity, risk adjustment techniques, and interpretation.

Workforce and staffing measures are often suggested as better choices for linking payment incentives to quality performance. A large body of evidence supports the contribution of direct care staff – nurses, nursing assistants, home health aides and personal care attendants -- to quality outcomes in long-term care.

Minimum staffing levels among direct care workers are one element of workforce-related inputs to quality. In addition, studies indicate that quality outcomes also depend on the education and training of direct care staff, quality of supervision and teamwork, leadership and organizational culture, salaries and benefits, and job satisfaction. Which of these workforce-related measures is best suited to a pay-for-performance system remains unclear at this point. Studies are underway to evaluate which staffing measures are most strongly correlated with quality outcomes.

If workforce-related measures were used to reward providers for quality, the payment scheme itself must be properly structured to ensure that any extra funds will create the right incentives for quality improvement. The paper discusses some of these design issues, including the size of the incentive, the need for additional revenue to outweigh the cost of attaining the target measure, whether to use relative or absolute scores, and providers' perception of the target measure being achievable.

The notion of basing payment on the achievement of certain performance standards is not new in long-term care. The paper reviews the experience of state Medicaid and other programs that experimented with quality improvement incentives in the 1980s. It also examines preliminary results of the Iowa Medicaid nursing facility "accountability measures" program, begun in 2002, which awards bonuses to nursing facilities that attain certain measures. Minnesota is developing a similar approach, described in the paper, in its redesign of Medicaid payment policy for nursing homes. In both Iowa and Minnesota, and in several other states, direct care staffing measures feature prominently in the design of quality incentive payments.

The paper concludes that consensus is building among provider organizations, consumer advocates and worker associations that direct care staffing measures may be a better starting point for linking payment to quality, until case-mix adjustment techniques and other technical issues make patient outcome measures more reliable. Progress in this direction will hinge on important design issues, particularly whether the payment rewards create winners and losers among provider organizations or puts extra money on the table to reward those who meet or exceed performance standards.

As more Medicaid programs, and potentially the federal Medicare program, design experiments to test different approaches to linking pay to performance, it will be critical to evaluate their effects on direct care workers, providers, and patients.

LINKING PAYMENT TO LONG-TERM CARE QUALITY: CAN DIRECT CARE STAFFING MEASURES BUILD THE FOUNDATION?

Introduction

"Pay-for-performance" seems to be everywhere in the health care purchasing landscape these days. Leading employer health plans are experimenting with it to get better value for their health benefit dollars. Medicare has a pilot program to pay a select group of hospitals for improving several quality measures; those in the top ten percent will be paid an extra reimbursement amount as a bonus. The Medicare Modernization Act passed by Congress in 2003 required the Institute of Medicine to study ways to reward physicians who can show improved patient outcomes.

Last November, a bill was introduced in the US Congress that would require the federal government to develop and test methods for linking Medicare nursing home payment to quality outcomes. The National Quality Forum, a public-private partnership created in 1999, recently announced a new project to develop guiding principles for pay-for-performance programs. The American Medical Association cited the trend towards pay-for-performance as a "tsunami building offshore in a sea of stakeholder unrest, threatening those who are not prepared."

In the long-term care field, there are big hurdles to overcome in designing appropriate pay-for-performance programs. For which performance measures should payers hold long-term care providers accountable? Are current methods for adjusting for case-mix reliable enough to use in awarding performance add-ons? If Medicare took the lead, could it affect provider behavior, when Medicare comprises only about 15% of total long-term care expenditures and the outcomes for Medicare short-stay patients are so different from longer-stay Medicaid and private pay patients? What can be learned from state Medicaid programs' efforts to reward nursing homes that deliver higher quality care?

Since staffing is one of the strongest determinants of long-term care quality, this paper explores the potential for using staffing measures as the basis for developing pay-for-performance in long-term care (LTC). It focuses on the implications for direct care staff – the nursing assistants, home health aides and personal care attendants who work on the frontline, providing the most hands-on care to LTC clients. Because most of the debate and studies on the subject deal with nursing facilities, the paper focuses on those entities. The paper examines some key questions:

- Does it make sense to reward LTC providers for their investments in direct care staff? Will doing so improve quality of care and quality of life for residents and clients?

- Which staffing measures are most strongly associated with quality improvement? How could pay-for-performance programs be designed to target these measures?

- How have Medicaid agencies, which are the primary public payers of LTC services, structured reimbursement policies to encourage staffing investments? What are state innovators, such as Iowa and Minnesota, doing to chart the way forward?

- What are the prospects for the federal Medicare program to pay long-term care providers for improved performance, and for using staffing indicators as the basis for extra payments?

Putting "Performance" in Context

The pay-for-performance concept is simple and therefore appealing. It generally involves health care payers rewarding health care providers for delivering high quality care.[1] But as with other catch phrases, whose popularity can obscure the meaning, the term "performance" often stands for different things depending on the health care setting and payer goals.

Both private and public health insurance plans have, for a long time, used payment policy to influence health provider practices. For them, the performance goal has mostly been to lower costs by limiting the amount of services provided. Now when payers and health plans talk about performance, it more often refers to delivering quality care or producing better results for the same or less cost.

But quality, like performance, comes in many flavors. Purists insist that the only quality that matters is clinical outcomes – i.e., better patient health status or functioning. Others who are less sanguine about the reliability of existing tools for adjusting for case mix (each facility's mix of patients with varying acuity and health care needs) prefer a focus on clinical processes. This usually means adherence to clinical guidelines for various diseases and conditions. In the acute care sector, for example, most current or proposed pay-for-performance programs focus on preventive care processes such as timely vaccinations and cancer screenings, and whether the right drugs are being prescribed for chronic conditions like asthma, diabetes and heart conditions. Only a few programs, such as Bridges to Excellence which is backed by large employers such as Ford Motor Co., GE, Procter and Gamble, Verizon and UPS, are also rewarding physicians for producing desirable clinical outcomes.

The meaning of performance can be stretched even further. Medicare officials recently heralded the simple reporting of quality data as a measure of performance. All hospitals that supplied data on how well they did in providing standard treatment for a few common conditions qualified for a 2004 cost-of-living increase;

[1] The term pay-for-performance is often used in the human resource management field to denote policies for employee compensation linked to achievement of specific goals or targets. That is not the subject of this paper.

all but 2% of hospitals complied.[2] This is seen, however, as a precursor to paying hospitals based on providing quality care, defined according to widely accepted clinical process guidelines.

Quality-related performance measures in the long-term care setting are actually further along than in the acute care setting. All federally certified nursing homes are required to regularly assess patients' clinical status according to Minimum Data Set (MDS) guidelines and submit the data to the federal government. Federally certified home health agencies are required to assess patients according to the Outcome Assessment and Information Set (OASIS) upon admission, discharge, transfer to another provider or recertification. Both MDS and OASIS provide clinical information that is then translated into quality indicators.

For example, using patient-level MDS clinical data, the federal Centers for Medicare and Medicaid Services (CMS) created Nursing Home Compare, a web-based listing of nursing home quality indicators (www.medicare.gov/NHcompare). The indicators include a mix of process and outcome measures. But since patients who receive long-term care services often have poor prospects for improvement in their underlying health condition (e.g. heart disease, diabetes, dementia or mental impairment), the quality indicators include measures of patient *functioning* or other markers that are preventable or amenable to improvement, such as pressure sores, the use of physically restraints; and how often patients spend most of their time in a bed or chair. For Home Health Compare, (www.medicare/gov/HHCompare), CMS used OASIS data to select home health agency quality measures emphasizing improvement or maintenance of patients' ability to get around with minimal help and perform basic daily activities.

But it is one thing to collect and track such performance measures as a means for allowing consumers to compare agencies, or for identifying problems that agencies can address through internal quality improvement. It is another matter to use such quality indicators (QIs) as the basis for pay differentials. At the individual patient level, some have questioned the validity of MDS measures due to differences in clinical interpretation (sometimes called "ascertainment bias"), particularly for patients with cognitive impairment. At the facility or organization level, some believe that the methods used to adjust quality indicators for case-mix can lead to organizations receiving low QIs due to unavoidable declines in patient conditions or even random factors (Ryan, Stone and Raynor, 2004). Perceived flaws in case-mix adjustment systems have led to a search for alternatives.

Staffing (Carefully Defined) is a Key to Quality

Staffing measures are most often suggested as a better choice for linking payment incentives to quality performance. A background paper prepared for a 1996 Institute of Medicine report concluded that due to the positive relationship between quality and nursing staff levels or qualities, "reimbursement incentives could be

[2] G. Kolata, "Program Coaxes Hospitals to See Treatments Under Their Notes," *New York Times,* December 25, 2004

directed toward increasing staffing levels and educating and training staff in nursing facilities." (Harrington in IOM, 1996) More recent reports by the Institute of Medicine (IOM 2001, IOM 2004) reaffirmed that there is "abundant evidence" showing that "quality of care depends largely on the performance of the caregiving workforce."

A federal report to Congress on the appropriateness of minimum nursing staff ratios in nursing homes (CMS, 2002) likewise concluded that quality of care improved with incremental increases in staffing up to about 2.4 certified nursing assistant hours per resident day. And a recent study (Schnelle, et.al., 2004) found that nursing homes with the highest total staffing levels (4.9 hours per resident day) had significantly better resident care process indicators than those with the lowest staffing levels (2.8 hours per resident per day). The strongest effect of higher staffing levels on the 13 care process measures examined were those related to feeding assistance.

While the IOM and CMS reports highlight the importance of achieving minimum staffing levels for nurses and direct care workers, they stress it as a necessary but not sufficient condition for improving quality of care and quality of life for nursing home residents. Education and training of staff, supervision, environmental conditions, leadership and organizational culture, salaries and benefits, and job satisfaction also contribute to resident quality of care. The 2004 IOM report in particular stressed that to improve quality, health care organizations must not only have adequate numbers of staff, but also create work environments that help to retain nurses and nursing assistants and provide orientation programs for newly hired staff and continuing education for existing staff.

Are staffing measures really the best ones to use in LTC payment incentive programs? Some caution that neither staffing measures, nor improved processes of care, are the strongest predictors of observed differences in quality **outcomes** among nursing home patients (Grabowski, Angelelli and Mor, 2004). The authors conclude from a recent study that "the overall munificence of states' Medicaid programs, not necessarily more staffing, better training or improved processes of care, is at the root of some of the observed differences in outcomes." In the study, Medicaid rate generosity was associated with lower use of physical restraints and pressure ulcer incidence.[3]

For that reason, they suggest incentives that directly link payment rates to improved patient outcomes. They cite the example of an experiment in San Diego in the 1980s that produced better health outcomes for nursing home residents by offering monetary incentives for clear and tangible improvements in residents' health or functioning (Norton, 1992).[4] An evaluation of another quality incentive

[3] A 2002 GAO study did not find a clear relationship between nursing home spending per resident day and the number of serious quality problems, but it was only conducted in three states (US GAO, 2002).

[4] An earlier study said that the San Diego experiment did not produce any evidence showing that extra payments were spent on extra care (Meiners et al., 1985), but the study by

payment program in Illinois in the late 1990s also warned that for structure and process criteria to work, they "must be clearly linked to changes in client conditions or other quality objectives." (Geron, 1991) Because the link can be hard to establish, it urged moving away from structure and process measures to assessment of outcomes directly.

Yet, there remain a compelling set of pragmatic reasons for choosing staffing measures as the basis for rewarding providers for improved quality – at least initially. First, nearly all key stakeholders – providers, consumers, and workers and policymakers – already agree that staffing inputs are important to long-term care quality. This consensus has formed part of the rationale for Medicaid wage pass-throughs in about half the states, which provide extra funds for spending on direct care staff wages and benefits. It is also the driving force behind the Medicare nursing facility pay increase of 2003; nursing homes can get an extra 3.25 percent rate increase if they spend it on direct care staff such as nurses and nursing assistants.

Second, many believe that staffing indicators are more measurable and reliable than MDS client-related indicators, which continue to be plagued by variability in how the assessments are done and who does them. MDS-based quality indicators have other problems as well; for instance, studies have found few differences in care processes between facilities that score well and those that score poorly on MDS indicators. Plus, because quality of care is multi-dimensional, facilities that score well on one indicator may do poorly on another.[5] Even if QIs were perfect, it begs the question: which would be best in a pay-for-performance system?

Finally, staffing investments and certain workforce-related outcomes are seen as more within provider control than many other measures of patient functioning that are publicly reported.

But Which Staffing Measures?

Exactly which types of staffing measures are valid proxies for quality is the topic of a study currently underway by Abt Associates, in collaboration with the Colorado Foundation for Medical Care (a quality improvement organization) and researchers at the Universities of Colorado and Missouri. Commissioned by CMS, the study's purpose is to develop measures of nursing home staffing that can be used for public

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Norton used a more appropriate statistical model and did find significant and positive effects.

[5] Many studies and efforts are underway to improve the validity, risk adjustment techniques, and interpretation of patient outcome measures. Readers interested in this issue are referred to an in-depth report by Capitman and colleagues (2004) for the National Commission for Quality Long-Term Care, established by the National Quality Forum. The report discusses five major shortcomings in outcomes-based quality indicators (QIs) and what's needed to correct them: 1) difficulty in consistently finding reliability and validity of QIs in practice settings, 2) validity of QIs as indicators quality, 3) uncertain linkages among measures, 4) weak regulation in many states, and 5) questionable impacts of outcomes-based QIs on care outcomes.

reporting on quality. The recommended staffing measures may be added to the list of nursing home quality measures reported on CMS' website, Nursing Home Compare, if the evidence strongly supports their contribution to quality.

Most groups with a stake in the outcome of the study agree that staffing numbers alone should not be used. They suggest the addition of such things as retention, staff competencies, and level of training. Other studies suggest that high turnover may negatively affect quality of care and quality of life for residents. However, it doesn't necessarily follow that one should use *overall* turnover rates as a measure of quality. Barry (2002) found that nursing facilities with a stable core staff of direct care workers but high turnover among a small subset of workers due to weeding out inappropriate hires may produce better patient outcomes than facilities reporting lower overall turnover. Some would go even further to include measures of staff empowerment and staff satisfaction.

Regardless of which staffing measures are recommended, there are big concerns about how to adjust them for patient acuity or case mix. If staffing levels were reported publicly, for example, it would be important to indicate whether a higher or lower staffing level was called for based on the differences in the needs and acuity of the facility's residents.

There are also practical worries about the accuracy and ease of collecting the data on which the measures are based. For example, according to the study's literature review, "Medicaid cost reports for a few states collect turnover information, but a new data collection instrument would be required if the public reporting system were to include turnover and/or staff retention." Payroll data may be a possible source of data for this measure if it were included. The CMS study group in fact decided to collect payroll data from large national chains of nursing homes in order to runs tests designed to assess how it could be adjusted for patient risk profiles.

A report and recommendations on the first phase of the study is expected to go to CMS in the summer 2005. A second phase of the study, if funded, will try to validate the data and examine the relationship between staffing and other quality measures.

Designing a Payment Incentive that Works

If staffing measures were chosen as the basis for performance incentive payments, just dangling some money in front of providers won't alter their behavior unless it is properly structured. Certain features must be built into any payment system to ensure that extra funds will create the right incentives for quality improvement and be used to support the inputs or processes that make the biggest contribution to it.

First, the size of incentive is critical. Both the amount of the bonus and the payer's contribution to total revenues determine how much can be gained by working towards the desired end. The extra payment must be large enough to motivate providers to make needed changes. The potential gain is also influenced by the proportion of the providers' revenue that is derived from the payer offering pay

incentives. The larger the percentage of revenue from the payer, the more the provider has an incentive to change their normal operations to meet the goal. Nursing homes and home health agencies whose Medicare or Medicaid payments are significant relative to total revenue would have greater incentive to change their behavior than organizations relying on private pay, if either of these public payers were to adopt pay-for-performance programs. And if these two big public payers moved towards pay-for-performance, there might be spillover effects on private payers of long-term care, such as managed care plans and private LTC insurance companies.

Second, the potential for additional revenue must be greater than the expected costs of achieving the performance goal or standard. In other words, the net extra income drives provider behavior. If the cost of doing something to reach the performance standard is more than the expected return from the incentive payment, it will fail regardless of the size of the payment.

Another design question is how high to set the bar. For example, should the incentive payment be available to those that meet an absolute standard? Or should it be awarded only to those who do well relative to their peers? Scott Miyake Geron, a researcher at Boston University, argues for relative scoring. “The problem with absolute standards is that, for many measures, the results are uniformly high. Take resident satisfaction scores, on which most providers tend to do pretty well overall. The worst thing you can do is to design a program that allows a weak provider to get a good score. It undermines the integrity of the whole program.”

Geron also emphasized that relative scores are critical for outcome measures. “For example, if Mrs. Smith declines over time from needing help with three activities of daily living (ADLs) to five ADLs, it sounds like a bad outcome. But if she declined less than others at her level of frailty over that same period, then her care may have been better than that received by someone else. This illustrates why case-mix adjustment of measures is so important.”

Likewise, there is the dilemma of whether to reward only those who meet absolute thresholds for quality versus those that have made substantial progress but may have started from a lower level. Some argue for a focus on the change score, rather than the absolute level because if the standards were set high, it would be impossible for low-performing providers to improve far or fast enough. The patients in the low-performing facilities would suffer as a result. On the other hand, change scores can produce skewed results if the denominator is small, e.g. high risk cases in some MDS quality indicators. This problem adds support to use of staffing measures rather than quality indicators as the basis for linking payment to performance.

Finally, there are a number of non-financial issues to consider in the design of an effective payment incentive, involving providers’ ability and willingness to respond. For example, do providers perceive the required changes to be attainable and within their control? If the incentive rewards increased staffing levels, providers may feel that local labor market shortages make it so hard to increase licensed or

even unlicensed nurse staffing levels that it doesn't make sense to try. In this case, some sort of adjustor for the local labor market might be needed.

Structural measures like staffing levels or process measures like the percent of direct care workers who complete special training programs may seem more within providers' power to control compared to an outcome measure like staff turnover or retention. The existence of proven methods and programs to achieve the goal, supported by reliable research, can also help increase providers' perception that improved performance is within reach.

State Long-Term Care Quality Incentives – A Brief History

To address quality problems in long-term care organizations, some states have been trying to devise alternatives to just penalizing bad performing organizations. A few have tried to offer long-term care organizations assistance and guidance to improve quality. And a few state Medicaid agencies created payment formulas to reward higher quality, based on certain performance indicators. What can we learn from these states' experiences and program designs about what worked and what didn't?

In the early 1980s Illinois' Medicaid agency established "QUIP" (Quality Improvement Program) to award nursing homes extra reimbursement for demonstrating achievement of certain quality-related measures. The indicators fell into six categories associated with quality of life: structure and environment, resident participation and choice, community and family participation, resident satisfaction, care plans and specialized intensive services. Those facilities that met the criteria won more "stars" and received more Medicaid funds; raising a one-star rating to a six-star rating could mean as much as an additional $100,000 in Medicaid payments each year. In 1989, total bonus payments amounted to about $20 million.

It might not sound like a huge amount, but it was apparently enough to provide an incentive. An evaluation of the QUIP program found that over time, more facilities applied for, and qualified to receive, bonus payments (Geron, 1991). The study found, however, that the validity of the individual measures and the relationship between achievement of QUIP standards and resident care quality was not firmly established. In one notorious example, after the state listed fish tanks as an example of things in structure and environment that were eligible for extra points, every nursing home in the state bought one – or rented one just for the QUIP survey. Lots of fish died and it did little or nothing to improve nursing home patient care. Some complained that the program focused too much on "paper compliance"; for example, care plan goals may have been established, but they didn't necessarily translate into real changes in resident care. In addition, some of the things in the QUIP program that qualified nursing homes for bonuses become requirements of the federal OBRA 87 law, rendering the system obsolete. The program ended a few years later.

Figure 1

Medicaid Nursing Home Payment Policies
How do they work now?

To consider how Medicaid programs might build quality payment incentives into their reimbursement systems, it is important to understand how Medicaid payment policies for nursing facilities are currently structured. Any incentive would represent an extra payment above the regular rate of reimbursement under the state's Medicaid system.

All 50 state Medicaid agencies pay nursing homes based on the price of inputs, rather than on the quality of care provided. Nursing homes are generally paid on a per diem, or daily, basis; in 2002, the national average was $118.00 (Grabowski, et.al., 2004). The ability to provide quality care depends first and foremost on the adequacy of this base rate in relation to costs. While labor costs differ around the country, $90 per day on average as in Illinois in 2002 almost certainly buys less quality and lower staffing levels than $118 per day.

Most states adjust the base payment rate according to the "case mix", i.e. the level of need of the residents in the nursing facility. Higher payments to facilities with more patients at greater acuity gives the facilities an incentive to serve such patients, who might otherwise be shunned, while diminishing the potential for high-need residents to be given substandard care. In addition, most state Medicaid agencies have designed reimbursement methods that give nursing facilities incentives to be more efficient and to spend less than the average costs across all facilities (U.S. GAO, 2003). For example, states may limit payment by setting separate ceilings for different cost centers, such as administrative and capital costs, and apply them to facilities in each peer group, which vary by size, location, hospital-based or freestanding, and type of ownership.

As of FY 2002, 39 states set rates prospectively to give nursing facilities the incentive to incur only necessary costs; those that can deliver care for less than the prospective rate make a profit, while those whose costs exceed the rate experience losses. Only two states had completely retrospective systems and seven states had a combination of the two (Grabowski, et.al., 2004). In practice, prospective payment systems can resemble retrospective systems if the base rate is updated yearly or if strong efficiency incentives are absent. With some notable exceptions like Illinois and New York, most states "rebase" reimbursement rates annually or every two to four years in line with actual facility costs and inflation rates.

Figure 1 continued

Medicaid payment policies can also be designed to give providers incentives to spend their revenues on certain types of costs. Payment systems that allow higher limits on direct care costs, which are more related to quality than administrative, capital or indirect costs, are thus more likely to assure minimum quality standards. Many states in fact offer incentives to all providers to concentrate resources on direct resident care provided by nurses and nursing assistants. For example, some states allow higher ceilings for direct care costs than they do for other types of costs. Some states exempt direct resident costs entirely from efficiency incentives. And about half the states have some type of add-on payments for wage or benefit enhancements to direct care staff (U.S. GAO, 2003).

Given the already built-in incentives to spend more on direct care nursing costs, any additional quality incentive payment targeted towards staffing would have to be aimed at other workforce-related measures or outcomes.

Other states have eliminated quality incentive add-on payments in recent years. But the termination of these programs appeared to be due to factors other than program effectiveness. For example, Colorado made $3 million in quality incentive payments to nursing facilities in FY 96-97. But the incentive payments were repealed in 2002 when the state lifted a cap on allowable cost increases, offsetting most of the financial loss to providers. The state was also seeking to save costs due to an impending state budget deficit in FY 2002-2003.

A New Generation of Quality Incentives Integrate Direct Care Staff

Iowa and Minnesota have drawn on these earlier state experiments in designing new payment systems, which incorporate a quality incentive component. Iowa's new nursing facility reimbursement system, introduced in 2002 and in full effect by July 2003 classifies nursing facilities into peer groups for the first time and introduced case mix adjustment to modify rates based on resident care costs.

In conjunction with these changes, Iowa established a voluntary system to award bonus points to nursing facilities based on ten "accountability measures" – results that the state wants to reward – which can be collected from readily available state data. Figure 2, next page, shows that three of the 10 measures address staffing issues (shown in bold).

According to a 2002 memo from the Iowa Department of Human Services describing the program, these measures "are objective, measurable and when considered in combination with each other, deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the

delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care." Half of the measures are relative scores – based on how well a facility performs relative to others -- while half are absolute scores.

Nursing facilities are eligible for extra Medicaid payments based on how many points they get, with a minimum of three required. For three or four points, the facilities receive 1 percent of the direct care and non-direct care medians (about a dollar per day more per Medicaid patient), for five or six points, they receive 2 percent and for seven or more points, they receive 3 percent. Facilities can win up to $3.14 more per diem. In the current fiscal year, 373 facilities qualified for an add-on; 57 facilities did not quality for any add-on. A little over $8 million was paid through add-ons in the most recent fiscal year.

According to Jennifer Steenblock, long-term care manager in the Iowa Department of Human Services, staffing-related data comes from facility cost reports. Providers supply the state with information based on rules and instructions regarding cost reports; a sample of providers is selected for full on-site audits to ensure accuracy of cost report data.

Figure 2

Iowa Medicaid Nursing Facility Accountability Measures

▪ Deficiency-free survey	2 points
▪ Substantial compliance with state licensing survey	1 point
▪ **Case-mix adjusted nursing staff hours at or above the 50th percentile of all nursing facilities**	**1 point (2 points if above 75th percentile)**
▪ Resident satisfaction scores at or above 50th percentile based on independently administered survey	1 point
▪ Resident advocate committee resolution rate at/above 60%	1 point
▪ **High employee retention rate (at/above 50th percentile)**	**1 point**
▪ High occupancy rate (at or above 95%)	1 point
▪ Low administrative costs (at/below 50th percentile) **and no contracted nursing staff ***	**1 point**
▪ Facility has special, licensed unit for care of residents with chronic confusion or dementing illness	1 point
▪ High Medicaid utilization (at/above 50th percentile)	1 point

* *program subsequently eliminated contracted nursing staff*

While there has not been any formal evaluation of the program yet, Brian Farrell, President and CEO of Bishop Drumm Retirement Center in Johnston Iowa says, "We have some indications that it has been successful. It recognizes those providers that have been doing the right things and it has helped raise the bar for others." Farrell, a member of an informal advisory committee to the state, cites as evidence of success a rise in the number of facilities with deficiency free surveys, which increased from 57 (13% of all facilities) in 2002-03 to 75 (17%) in 2004-05. Plus, the system is fairly easy and inexpensive to administer, an important factor since the state agency was not given any extra resources to run the program.

But the jury is still out on the program's long-term effect, says Farrell. For example, there is not yet enough data to indicate if the two major staffing-related measures – nursing hours provided and retention rate – have improved as a result of the program. Farrell also doubts that the extra payments are enough to convince any facility to make any major investments, i.e. to start up a new dementia unit to qualify for the special licensure measure. However, for motivated providers, they may be enough to encourage positive improvements. "No one is happy with all ten of the measures," he admits. "But taken as a whole, we are satisfied with them."

Neighboring Minnesota is pursuing a similar approach. The state has been trying since 2002 to design a new Medicaid payment approach that would reward both efficiency *and* quality of care. The goal is to move from a system based on costs, or the price of inputs, to one based on the value and quality of the care that providers actually deliver. Hence, it is called by some a "value-based reimbursement system". The new system, if adopted, would have a broader impact than in other states because Minnesota's nursing home payment policies must be followed by private payers as well, under its "rate equalization" law.

In 2004, the Minnesota Department of Human services outlined its proposal. Like other states, nursing home costs would be divided into four components: 1) direct care services, 2) support care services, which are all other operating costs like administration, dietary, housekeeping – known as "indirect costs" in many other states, 3) external fixed costs such as property and bed taxes, and 4) capital and property costs. The first two cost categories would be eligible for quality and efficiency rate adjustments, depending on each facility's rank relative to others.

The system would rely heavily on relative rankings. Facilities would be divided into 10 quality tiers based on 10 point increments. A facility that had low quality and low costs would get less than a specified target rate, while a low quality/high cost facility would get the target rate. High quality/low cost facility would get an incentive payment of about 8 percent above its costs, while a high quality/high cost facility would only get its costs reimbursed.

Proposed quality measures emphasize staffing-related indicators, such as nursing hours per case-mix adjusted resident day, staff turnover, staff retention, and use of pool staff. These four measures alone contribute almost two-thirds of the total possible points. The rest would be comprised of patient care quality indicators drawn from the MDS scores, no significant survey deficiencies, and the proportion of single rooms. Some complained about the lack of consumer, staff or family satisfaction scores in the mix of quality measures, while others believe the lack of

quality of life measures is a serious omission. Their objections led to a decision to add quality of life and resident satisfaction measures to round out the quality profile. The points allocated across the measures will change as a result.

One sticking point with an earlier draft of the proposal was that it adjusts prices to achieve budget neutrality. This was meant to reassure state legislators that the new program would not cost more than the current system. Because such a system creates winners and losers, state provider organizations pressed for a "hold-harmless" provision, to help providers transition to the new system over four years. Complaints were also raised about the system rewarding quality improvement retrospectively, rather than offering incentives for providers to improve quality in the future. "It's hard to improve quality with no new money to invest in activities that would raise it," says Lori Meyer, of the Minnesota Health and Housing Alliance. Negotiations are now centered on the amount of a funding increase to permit upfront investments in quality, following two years of frozen rates.

Findings from an analysis of winners and losers based on the collection of cost data in 2003-04, were supposed to have been presented to the legislature in time for the 2005 session and to the stakeholders – providers, consumers, and unions. But problems with the data have held up the results. Additional studies are also underway to examine relationships between direct care staff time spent with residents and specific care outcomes, to study acuity-based staffing models, and to estimate the costs associated with achieving the quality measures. If all goes as planned, the new system will be implemented in October 2006.

Other states are exploring similar directions. For example, in 2004 an advisory group to the Kansas Department on Aging recommended a quality incentive program be designed to replace the current "incentive factor" in Medicaid nursing facility reimbursement. Among the suggested components of the new program were nursing staff ratios, staff retention and turnover among direct care staff, resident satisfaction and occupancy levels.

A Role for Medicare Too?

The federal government may soon get in on the action too. In the last Congressional session, some bills were introduced that proposed rewarding quality in nursing homes through the Medicare payment system for the first time. For the most part, the bills favored linking payment to workforce-related performance measures, such as the amount spent on direct care nursing staff, or nursing home staffing level and mix.

One of the bills would have permitted the use of patient outcome measures as long as they could be "risk adjusted with sufficient precision to be used in a payment system". Risk adjustment issues take on particular importance for Medicare, since so many nursing facility patients whose admission is paid for by Medicare are short-stay, with higher needs and acuity levels than long-stay residents. The bill was reintroduced as HR 1166 in the 2005-06 Congress.

Figure 3

Better Jobs Better Care Initiatives
Test Non-Monetary Recognition Programs

Two of the five Better Jobs Better Care demonstration projects are developing programs that will offer non-monetary recognition for good performance. In these states, programs are explicitly rewarding direct care staff investments and improvement. **Vermont**'s recently introduced "Gold Star" program recognizes to nursing homes that institute evidence-based best practices in recruitment and retention of direct care staff. Nursing facilities that make a commitment to implement at least two workforce improvement practices are eligible for the Gold Stars. The stars do not qualify the facilities for a bonus in their Medicaid payments. But to win one of five annual Quality Awards of $25,000, starting in 2005 nursing homes are required to gain Gold Star recognition to be eligible.

North Carolina's recently christened New Organizational Vision Award (NC-NOVA) similarly focuses on staffing investments as a key quality improvement strategy. It creates a voluntary, special licensure program for home care agencies, adult care homes and nursing facilities that can demonstrate they have a positive workplace culture designed to improve the recruitment and retention of direct care workers.

Unlike wage pass-throughs or incentives to spend more money on direct care staff wages and benefits, the NOVA program focuses on human resource policies and management practices that foster a workplace climate conducive to quality caregiving. For example, the special licensure criteria focus on things like balanced and safe workloads, management support for creating a climate of respect for the frontline workers, and direct care worker input into care planning. And unlike wage pass-throughs, which are often available to all providers, NOVA will reward better performance by only those organizations that prove they meet the special licensure expectations.

Ultimately, North Carolina would like to use the special licensure designation as the basis for awarding Medicaid reimbursement differentials, or Medicaid wage pass-throughs, or other types of labor enhancements. And to address the question of whether the focus on direct care workers leads to higher quality outcomes for patients, University of North Carolina researchers plan to analyze the Minimum Data Set (MDS) scores for patients in nursing facilities that win NOVA special licensure to see if they have higher quality indicators.

Progress may not have to wait for Congress, however. CMS' Center for Medicare Management is planning a demonstration program on pay for performance in nursing homes. Design components have yet to be decided, including the most important, such as which quality domains to reward, appropriate indicators, and whether the scheme would have to be budget neutral.

Further consideration of how to align pay with performance in the Medicare program will also occur through an Institute of Medicine study mandated by the Medicare modernization act of 2003. The IOM is now cataloguing performance measures used by various public and private payment plans, evaluating their impact on provider behavior, and identifying options for changes to Medicare reimbursement policies. The report is due mid-2005.

Next Steps – Compromise and Evaluation of Experiments

Among provider organizations, consumer advocates and worker associations, consensus is building that to improve LTC quality, the traditional punitive approach must be balanced by positive incentives that reward providers who can demonstrate better quality. There is a strong argument for linking payment to measures of quality outcomes. After all, there may be many ways to achieve the desired results and one wouldn't want to stifle innovations or different combinations of structure (e.g. facility modifications) and processes (e.g. greater teamwork, use of technology, mix of staff with varying skills) that lead to them.

But serious questions remain about the adequacy of risk-adjustment techniques and the reliability of data sources to take into account differences in case-mix of individual providers on their outcome measures. It was controversial in the development of the quality measures for public reporting --Nursing Home Compare and Home Health Compare -- and would likely be even more contentious in developing quality measures for payment purposes.

There seems to be broader support for using indicators related to the direct care workforce as the basis for tying payment to quality. A growing body of evidence demonstrates the importance of workforce levels to quality of care outcomes. State Medicaid reimbursement policies have moved in this direction and are showing promise in changing provider behavior. CMS' nursing home quality improvement program has asked the nation's quality improvement organizations (QIOs) to focus on organizational culture change and workforce retention in the next scope of work starting in the fall of 2005. And, as anyone who has provided care to an older disabled person will testify, it's the stability, skills and compassion of frontline caregivers that make the biggest difference in quality of life, client satisfaction, and quality of care, on a daily basis.

Despite this emerging consensus, progress may hinge on the details of any proposed payment incentive. The biggest flashpoint seems to be the possibility that it will create winners and losers. That is, a payment incentive that takes funds away from the worst performers and gives it to the best performers will be opposed by provider associations, who view it as divisive and designed to shut some of them down. A commitment to quality, they argue, means putting extra funds into the system to reward those who meet or exceed the performance standard. To do otherwise would punish providers that have not been able to meet the standards, putting the clients they serve and workers they employ at risk. But with federal and state budgets strained by Medicaid and Medicare costs, this argument may lose out to the demands of cost containment.

For direct care workers, the implications of tying payment to workforce outcomes and to their own performance could be profound. On the one hand, it could give them a stronger stake in their organizations' success and highlight their contributions to quality care. And it would shift managers' focus to critical workforce "vital signs" that are sometimes neglected. There is the risk, however, that managers would try to pin the blame for poor performance on direct care staff who have the least power and may not be able to defend themselves.

As state Medicaid agencies, Medicare and perhaps a few private LTC insurance plans begin to experiment with linking payment to quality outcomes in nursing facilities, it will be critical to evaluate their impact on provider behaviors. Depending on how the programs are structured – the amount of the incentive, the types of quality measures used, the cost of achieving performance goals, and whether the measures are relative to all other providers – each may have different effects on providers' behavior. For that reason, it is critical to build in rigorous evaluation of any pay-for-performance systems that are tried in the long-term care arena. Such studies should help to explain their success or failure in producing the desired changes and quality outcomes for patients.

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