

## NURSING HOME PAY FOR PERFORMANCE

Senate Bill 110 (2006) requires the Health Facilities Association of Maryland (HFAM) and Mid-Atlantic LifeSpan (LifeSpan) to develop a proposal for linking nursing home payment to quality measures. The bill also requires the Department of Health and Mental Hygiene (DHMH) to submit a plan establishing such a linkage and propose a timetable for implementation. The Department is also directed to articulate the reasons for differences from the nursing home industry proposal. As the Joint Chairmen's Report points out, of the almost \$1 billion of Medicaid payments for nursing facility services, none currently is contingent upon performance criteria.

### P4P PRINCIPLES

The concept of Pay for Performance (P4P) in medicine has become an increasingly discussed topic as a cost effective means of eliminating wasteful health care spending, while improving patient outcomes. The effectiveness of various P4P initiatives has so far been inconclusive.<sup>1</sup> Positive benefits have been realized on specific evidence-based procedures, in particular various screening procedures and preventative tests where data on treatment and results are readily available.<sup>2</sup> As performance measures become less easily or less accurately recorded, and positive patient outcomes are not as straightforward, many researchers and analysts have raised concerns. While improving quality should be an across-the-board goal for both payers and providers, creating an incentive to focus upon one particular measured area of quality might create the incentive to lose focus on an unmeasured but equally important area or quality.<sup>3</sup>

Risk adjustment and case-mix weighted measures must be designed to discourage facilities from avoiding patients who have greater medical needs. Incentives must take geographic, demographic, and economic factors into consideration to reduce the potential of P4P creating or exacerbating health care disparities. Reporting systems must be simple, accurate, and well planned to avoid any potential gaming of the system to receive incentive payments without actually improving quality.

### P4P IN NURSING HOMES

The Centers for Medicare and Medicaid Services (CMS) is developing a demonstration project around pay-for-performance in Medicare payments for nursing homes. The CMS demonstration, with significant contracted research by Abt Associates, Inc., has presented a comprehensive series of measures for primarily post-acute nursing home services.<sup>4</sup> While many of the Abt recommendations may apply to any state's Medicaid program, some fundamental

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<sup>1</sup> Hahn, "Pay-for-Performance in Health Care" CRS Report for Congress, (Dec. 2006) CRS 19-21

<sup>2</sup> Rosenthal, et. al. "Early Experience with Pay-For-Performance: From Concept to Practice", *Commonwealth Fund* Pub. #865 (Oct. 2005).

<sup>3</sup> Shea and Simon, "The Limits of Pay for Performance" *Provider* 59 (Oct. 2005).

<sup>4</sup> Abt Associates, Inc. "Quality Monitoring for Medicare Global Payment Demonstrations: Nursing Home Quality-Based Purchasing Demonstration" Prepared for CMS (June 2006).

differences exist between Medicare-covered stays and Medicaid-paid services. Medicaid residents typically require longer-term care, and the concepts of positive health outcomes vary widely from short-stay rehabilitation patients. Therefore, the CMS demonstration is not completely adequate for this proposal.

The HFAM/LifeSpan recommendation strongly suggests that any quality measures “must be objective, measurable and within the provider’s control,” and that any new measure “minimize administrative burden and not duplicate existing data or reporting systems.”<sup>5</sup> They also propose that evidence-based measures, those that have some statistical linkage to improved patient outcomes, must be developed where possible. The cost of implementation and administration of these measures must be reasonably controlled for the nursing home industry, and a standardized reporting system will need to be developed by DHMH. The industry has requested that any such payment system not be “punitive.” It is their belief that any P4P initiative should incentivize quality performance and improvements, but not add additional strain to any facility that may be having difficulties meeting standards.

## **GENERAL RECOMMENDATIONS**

Funds allocated to P4P incentives would be distributed as an add-on to the current per diem rate system. Incentives would appear as separate bonus payments so that facilities can see the results of quality improvements more readily.

The Department considered tying P4P payments to a particular cost center (Nursing), or to an adjustment to a facility’s efficiency (allowable profit) calculation. These approaches add complexity to the system and could dilute the effect of quality improvements. A concern raised by both DHMH and the provider organization representatives focuses on who should receive P4P benefits – the highest performing facilities, or facilities that show the most improvement in quality measures over a given period of time. The Abt Associates, Inc. study for CMS suggested that any benefit should target both areas equally. The improving facilities offer a greater challenge of measurement since current tools available may not give the most reliable or comparable data. It raises the question as to whether the Department truly wishes to reward formerly underperforming facilities for simply reaching average levels of quality, while not rewarding other facilities that consistently perform adequately.

The Department also recommends that financial sources for any incentive be based on separately budgeted funds, funds derived from proposed quality assessments, or funds diverted from a specific current budget area like unspent nursing service payments. The Department is not inclined to propose funding any portion of a P4P benefits with funds derived from penalties or fines from low performing facilities. The Office of Health Care Quality already has a system in place for fining facilities with sub-standard quality measures, and the Department feels that using a similar system to fund quality improvement would be duplicative and potentially counter-productive. Recent trends in nursing facility quality research have placed an emphasis on promoting positive quality indicators rather than penalizing negative factors. The program’s goal will not be achieved by depriving under-performing facilities of the resources needed to improve quality of care.

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<sup>5</sup> Kauffman (Lifespan) and Ray (HFAM). Response letter to State of Maryland Senate Budget & Taxation and House Appropriations Committees. (Nov. 2006).

DHMH recommends that a baseline period must first be established with agreed upon measures to properly calibrate any P4P measurement scale. Fiscal Year 2009 would appear to be the earliest time when a P4P system could be integrated to the rate setting system.

The Department has identified key areas that can currently be measured with minimal statistical accuracy to establish baselines for quality performance. The measures would be assigned point values based on performance standards and/or percentile ranking scores. The P4P incentives would be distributed among the higher scoring and the most improved facilities. These areas, along with a possible weight for each measure, are as follows:

- Staffing - 30%
- Client Surveys - 30%
- Quality Surveys - 20%
- Patient Outcomes - 20%

### ***Staffing***

A major component of any P4P proposal should center on staffing. The *Advancing Excellence in America's Nursing Homes* campaign introduced some leading measurement indicators to predict good quality performances in nursing facilities.<sup>6</sup> Among the top recommendations was a focus upon improved staffing measurements. Maintaining qualified and experienced nursing staff is a challenge for many facilities that often must compete with higher paying labor force competitors in their coverage areas. However, maintaining appropriate staff levels, reducing agency staffing hours, and reducing employee turnover have shown solid indications to improved resident well being, as well as reduced likelihood of medical errors or preventable injuries. In a study of 59 nursing homes, researchers found that for each proportionate loss of an RN (per FTE/100 beds) the risk of infection increased almost 30 percent and the risk of hospitalization increased more than 80 percent.<sup>7</sup>

The Department is leaning towards focusing on total hours of nursing, adjusted for patient acuity mix for each facility. It would warrant further study as to whether facilities proportionately lacking in RNs fare particularly worse than facilities lacking in total staffing levels.

Agency hours are another factor identified by quality researchers. Agency nurses are not only expensive, but they have fewer personal connections with the residents, and high level of agency staff is perceived to correlate negatively with quality. DHMH and the Industry have generally concluded that due to the high cost of Agency nurses, additional incentive may not be necessary to reduce their use.

Nursing staff turnover rates is perhaps the most intriguing indicator. While a readily available tool to measure turnover is not available, the industry representatives have expressed

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<sup>6</sup> NHQC Website: [http://www.nhqualitycampaign.org/star\\_index.aspx?controls=goals](http://www.nhqualitycampaign.org/star_index.aspx?controls=goals)

<sup>7</sup> Zimmerman S, Gruber-Baldinin AL, Hebel JR, Sloane PD, Magaziner J., "Nursing home nursing home risk factors for infection and hospitalization: importance of registered nurse turnover, administration, and social factors." *Journal of the American Geriatric Society* 50:1987–1995. 2002

that it would not be overly difficult to provide “date of hire” information on next year’s wage survey. Adopting the theory that continuity of service is vitally important for nursing home residents, it would follow that facilities with the most longevity of experience among their staff would have higher levels of patient satisfaction and positive outcomes.

The current reimbursement method for nursing services establishes standard per diem rates based upon a work measurement study of the average amount of time and staffing mix for the various levels of care (i.e., light, moderate, heavy and heavy special) and nursing procedures. An annual wage survey provides data to ascertain the current cost to provide services in each of 5 geographic regions of the State. Program payments for nursing services are subject to a cost settlement process. Providers that spend less than the standard per diem reimbursement amount for services provided retain 60 percent of the difference between their costs and reimbursement, up to 3.15 percent of the standard rates. Although the Department continues to support the inclusion of efficiency incentives as an integral part of the payment methodology, it is questionable if these rewards should be available to providers that underspend in the Nursing Cost Center and fail to maintain a desirable level of quality. The Program projects in Fiscal Year 2007 that \$10.2 million in unspent nursing service payments will be retained by providers as profit in the Nursing Cost Center. Notwithstanding the nursing home industry’s strong recommendation that any P4P proposal should be non-punitive, the Department should consider that some portion of the \$10.2 million might be reallocated to create a funding source for P4P.

Recommendations:

- Focus on total staffing levels, adjusted for acuity
- Track turnover rates
- Consider reallocation of efficiency incentives

*Client Survey*

The Abt Associates recommendations did not value client survey results as much as other quality initiatives, probably due to the short term nature of Medicare nursing home patients. Since nursing homes are the fundamental providers of most daily services for their residents, long term care residents’ opinions as to how well they perceive their environs should be component to the P4P system. The Maryland Nursing Home Family Satisfaction Survey Pilot, developed by the Maryland Health Care Commission (MHCC), is an instrument containing 53 questions organized into overall measures of satisfaction, with the following 6 categories “representing areas of care and life”:<sup>8</sup>

Domains

- Staff and Administration
- Physical Environment
- Activities
- Personal Care Services
- Food and Meals
- Residents’ Personal Rights

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<sup>8</sup> MHCC website:  
<http://mhcc.maryland.gov/consumerinfo/nhguide/>

While this pilot study looked only at general trends, the survey results and techniques could be used to create a basic ranking system for facilities. This tool would be especially useful in recognizing facilities that show improvement over time.

### ***Quality Surveys***

The Office of Health Care Quality has a readily available database of survey results ranging from minor infractions to major incidences of sub-standard care. The State's inspection survey is a measure of a facility's ability to meet the minimum requirements under federal law. Each deficiency category can be assigned a weighting factor by which the number of deficiencies each nursing home has in that category is multiplied. The higher the score, the fewer points a nursing home is awarded. After appropriate baseline measurements, percentile scores can be calculated to add to the overall P4P scoring system.

While deficiencies are primarily specific incidents, the Department would also like to consider repeat offenses in back to back surveys as a potential negative factor for any P4P benefit. It would not be contrary to the spirit of P4P to reward facilities that show improvements from sub-standard results to more average results, but depending upon how the final P4P point system is designed, it may be necessary to create certain automatic disqualification scores. By excluding homes with egregious deficiencies or patterns of deficiencies, it is ensured that these facilities would not receive rewards from the State.

### ***Patient Outcomes***

A centerpiece of the Medicare demonstration and the MHCC home ranking survey focuses upon certain outcome-based quality indicators.<sup>9</sup> While all of these measures are not necessarily tailored to the needs of long term care residents, some measures may be appropriate. Records are maintained by MHCC ranking facilities as either being among the top 20 percent, bottom 10 percent, or "All Others." The measures focusing more on chronic conditions would appear to be the most suitable. Abt Associates selected five long-stay Quality Indicators (QIs), though more are available. Abt selected these measures since they were the least likely to be affected by factors not under the control of a nursing facility.

#### **Long Stay QIs**

- Percent of residents whose need for help with daily activities has increased
- Percent of residents whose ability to move about in and around their room got worse
- Percent of high-risk residents who have pressure sores
- Percent of residents who have/had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained

Since these measures are already being recorded, additional reporting requirements would not be imposed on providers.

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<sup>9</sup> CMS website:  
[http://www.cms.hhs.gov/NursingHomeQualityInits/10\\_NHQQQualityMeasures.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/10_NHQQQualityMeasures.asp)

## **CONCLUSION**

DHMH recommends that P4P incentive should be funded by a separately budgeted pool of funds. A portion of the unspent nursing service payments or revenues from proposed quality assessments should be considered as possible funding sources. Incentives should be targeted to the top performers, but significant weight should be given to recognize improvement. After baseline surveys are conducted and evaluated, DHMH will be able to devise a scale including Staffing, Customer Satisfaction, Inspection Survey, and Clinical Outcome data which will allow the creation of a point system for overall quality and improvements over previous year results. If appropriate, add-ons to the per diem rate can be stepped (\$3, \$2, \$1). The Department would prefer to award a sufficiently meaningful amount of funding through P4P so as to truly reward good quality, and not merely inflate reimbursements with no apparent change in behavior or benefit for consumers.

The Department is committed to working collaboratively with nursing home industry representatives in order to establish baseline data, scoring and payment criteria. Such action should provide a basis for a funding request for Fiscal Year 2009.