Washington State
Department of Social
& Health Services

Report to the Legislature

Report on Designing a System of Skilled Nursing Facility Quality Incentive Payments

RCW 74.48.090

December 15, 2011

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Executive Summary

RCW 74.48.090 required the Department of Social and Health Services and the Department of Health to consult with the Washington State Health Care Association and Aging Services of Washington to design a system of skilled nursing facility quality incentive payments – also known as a pay-for-performance (P4P) program. After initial conversations with the associations, it was decided to expand the membership of the workgroup by including this subject with several others being considered by a larger group. Representatives of individual nursing facilities and Providence Health Care were included. The workgroup met four times and considered a variety of information from available sources.

The group's consensus was that the Department should not begin to implement a P4P program at this time. While the group generally supported the concept of P4P, it felt that there was insufficient time to design a system, and that the current difficult budget environment was not an optimum time for such an effort. The Departments, while respecting the conclusions of the workgroup, believe that it would be advisable to proceed with at least a simplified, basic P4P program now, to continue the momentum behind this idea and take advantage of a currently available source of funding.

Summary of Action by the Department

In RCW 74.48.090, the Legislature specifically designated five principles to form the basis of a P4P system:

> (a) **Evidence-based treatment and processes** shall be used to improve health care outcomes for skilled nursing facility residents;
>
> (b) Effective purchasing strategies to improve the quality of health care services should involve the use of **common quality improvement measures**, while recognizing that some measures may not be appropriate for application to facilities with high bariatric, behaviorally challenged, or rehabilitation populations;
>
> (c) Quality measures chosen for the system should be **consistent with the standards that have been developed by national quality improvement organizations,** such as the national quality forum, the federal centers for Medicare and Medicaid services, or the federal agency for healthcare research and quality. New reporting burdens to skilled nursing facilities should be minimized by giving priority to measures skilled nursing facilities that are currently required to report to governmental agencies, such as the nursing home compare measures collected by the federal centers for Medicare and Medicaid services;
>
> (d) **Benchmarks** for each quality improvement measure should be set at levels **that are feasible** for skilled nursing facilities to achieve, **yet represent real improvements** in quality and performance for a majority of skilled nursing facilities in Washington state; and

> (e) Skilled nursing facilities performance and incentive payments should be designed in a manner such that **all facilities in Washington are able to receive the incentive payments** if performance is at or above the benchmark score set in the system established under this section.
> (emphases added)

The Legislature also provided a source of potential funding for the P4P system. In reference to the nursing facility safety net assessment created elsewhere in the act, the Legislature provided:

> (2) Pursuant to an appropriation by the legislature, for state fiscal year 2013 and each fiscal year thereafter, assessments may be increased to support an additional one percent increase in skilled nursing facility reimbursement rates for facilities that meet the quality incentive benchmarks established under this section.

The task of complying with this mandate was given to the Office of Rates Management (ORM) within the Aging and Disability Services Administration (ADSA). The ORM includes the section that sets Medicaid rates paid to nursing facilities under Chapters 74.46 and 74.48 RCW.

The ORM convened a workgroup of stakeholders interested in nursing facilities. The workgroup met on August 2, 2011; August 23, 2011; October 27, 2011 and November 17, 2011. Those attending one or more meetings were:

Amber D. Lewis	Providence Health Care
Charlene Boyd	Providence Health Care
Vicki Christopherson	Providence Health Care
Deb Murphy	Aging Services of Washington
Paul Montgomery	Aging Services of Washington
Scott Sigmon	Aging Services of Washington
Rich Miller	Washington Health Care Association
Lauri St. Ours	Washington Health Care Association
Gwynn Rucker	Chair, Washington Health Care Association
Nick Federici	Lobbyist, Health Care Issues
Sahar Banijamali	Service Employees International Union
Misha Werchkul	Service Employees International Union
Carma Matti-Jackson	Senior Fiscal Analyst, House Ways and Means, Health and Human Services Subcommittee
MaryAnne Lindeblad	Assistant Secretary, Aging and Disability Services Administration
Chanh Ly	Director, Management Services Division, Aging and Disability Services Administration
Ken Callaghan	Office of Rates Management, Aging and Disability Services Administration
Ed Southon	Office of Rates Management, Aging and Disability Services Administration
Kendra Pitzler	Department of Health

Barbara Rynyon	Department of Health
Janis Sigman	Department of Health
Edd Giger	Central Budget, Department of Social and Health Services
Bea-Alise Rector	Home and Community Services Division, Department of Social and Health Services
Leslie Emerick	Home Care Association of Washington
Ellen Silverman	Health Care Authority

The current legislative mandate needs to be placed in context. In 2010, the Legislature appropriated funds to investigate a P4P system. Section 206 of the supplemental operating budget appropriated $100,000 for the Department of Social and Health Services to contract with an outside consultant to evaluate and make recommendations on a P4P payment program. The consultant was to develop a report to include best practices used in other states for P4P strategies incorporated into Medicaid nursing home payment systems, the relevance of existing research to Washington state, a summary and review of suggestions for P4P performance strategies provided by nursing home stakeholders in the state, and an evaluation of the effectiveness on a variety of performance measures.

The Department contracted with L&M Policy Research, LLC, of Washington DC. L&M's Final Report, entitled "Strategies in Pay-For-Performance" was delivered May 18, 2011. The entire report is at: w.aasa.dshs.wa.gov/professional/rates/reports/. A copy of the Executive Summary of the Final Report is attached to this report. It is only 10 pages long, but does an excellent job of summarizing the full 155 page report. It does a particularly good job of describing the researchers' efforts in contacting the various Washington stakeholders in the P4P issue, and the stakeholders' responses. The present report's brevity is largely a result of not wishing to repeat what was already said in L&M's Executive Summary, and reading the Summary is highly recommended.

L&M's report included the following recommendations for a P4P program for Washington:

- **Include a range of quality measures in constructing performance scores.** Single measure systems risk penalizing providers who perform well overall. Multiple measure systems offer a more accurate assessment of performance.
- **Reward facilities based on composite measure scores.** Rather than paying on individual quality indicators, the quality measures selected should be pooled to create a total composite score.
- **Blend payment based on both absolute performance and improvement.** Basing a portion of the payment on absolute performance would benefit current high-performing facilities. Basing another portion on improvement would benefit and encourage current low- and medium-performing facilities. Both efforts are important.
- **Consider rewarding high performance, not penalizing poor performance.** Offer rewards to top scoring facilities, rather than penalizing the worst performing facilities.
- **Consider rewarding facilities on the basis of a fixed dollar add-on or bonus rather than as a percentage of the per diem rate.** A percentage

add-on would reward higher-cost, higher rate, facilities. A fixed dollar add-on would appear more equitable, and would exclusively reward performance.

- **Risk adjustment of quality measures is essential.** The underlying risk of residents must be taken into account in constructing performance scores. Otherwise, a P4P system can create incentives to admit healthier residents and restrict access to residents with more complex needs.
- **Be as transparent as possible.** Facilities should be given as much information as possible in all phases of the program.
- **Report measures/scores publicly.** All measures and scores should be reported on the department's website. Residents and their families, institutional discharge planners, and facilities themselves will all benefit.
- **Monitor the system for potential unintended consequences.** In P4P, facilities are rewarded only for those measures that are part of the program. Even though they are excluded from the P4P program, other measures remain important, and should be periodically monitored to assure that they are not deteriorating.
- **If possible, use new sources of revenue to fund reward payments.** To minimize risk to providers, as well as to encourage support for the program, the state should use new dollars to fund the program, rather than merely redistributing existing funds from "losers" to "winners."

The L&M Final Report was used to initiate the group's discussion. At the third meeting, on October 27, Bruce Thevenot of My Innerview participated by phone, at the request of the Washington Health Care Association. In his presentation, he made the following points:

- The best P4P programs have started small and slow, and listened to stakeholders.
- It is a good idea to collect data and examine results for awhile before actually starting to pay any money.
- Consumer/resident groups should be a part of the process.
- It generally costs approximately 2.5% to 3% of a state's existing Medicaid nursing facility level of spending to fund a P4P program.
- For the start-up of a good P4P program, a reasonable estimate might be around $300,000 in funds and 18 months in time.
- Georgia, Oklahoma, Colorado and Kansas are states that have relatively stable programs. Iowa has an older one that has been redone, but currently has no money.
- His five highest-recommended quality measurements or indicators for a P4P program would be:

  (1) ***Consumer satisfaction*** - from the residents if possible and then from the residents' families
  (2) ***Employee satisfaction*** *and engagement* (perhaps even more important than the first)
  (3) ***Employee retention***, especially in Direct Care (one-year tenure percentage is better than just turnover percentage, as some turnover is beneficial)

(4) ***Culture change*** (the Colorado, Oklahoma and Iowa programs have good examples), and

(5) ***Clinical performance***, which can include chronic care management and prevention. This metric can be difficult to measure because outcomes vary greatly.

Also at the October 27 meeting, Aging Services of Washington said that 1% of the safety net assessment (SNA) to fund the P4P program would be inadequate. Further, they felt that tying the funding of a P4P program to the SNA was not the best solution.

At the conclusion of the workgroup's meetings, the consensus of the workgroup was as follows:

1. The workgroup asked the Department not to proceed at this time to design and implement a specific P4P program. It was the consensus that the December 15, 2011 deadline does not allow adequate time to design the program.
2. Unanimously, the workgroup felt that any P4P program must come with new money to fund the system. Just redistributing existing funds between competing facilities will not be sufficient. Given the state's budgetary concerns, the workgroup did not feel there would be new money to fund the system.
3. Should there come a time when new funding is available to fund such a program, the workgroup overwhelmingly supported the idea of a trial period of shadow rates to see how such a program would operate before it actually started to pay money. Shadow rates were used to introduce the case-mix system to Washington's nursing facility Medicaid rate methodology.

The Departments respect the conclusions of the workgroup, and recognize that for any P4P program to be successful it must have the support of the majority of nursing facilities. Therefore, the Departments have not lightly made the decision to disagree with the workgroup's consensus. Nevertheless, they have done so for three reasons:

First, over the last several sessions, the Legislature has made its interest in P4P very clear. The Legislature sees P4P as a cost-effective way to improve quality of care for nursing facility residents.

Second, RCW 74.48.090 provides a source of potential funding for a P4P program: for SFY 2013 and each year thereafter, an increase in the nursing facility safety net assessment to fund up to a 1% increase in nursing facility reimbursement rates. The opportunity for this additional funding and reimbursement is too valuable to miss.

Third, a relatively simple P4P system can be initiated on a trial basis without incurring a great deal of up-front cost. It would keep the P4P momentum moving forward, rather than letting it stall out and have to be restarted later, if at all.

Recommendation

The Departments propose to proceed with the design of a P4P program, on the following bases:

- The guiding principles will be those set out in RCW 74.48.090 and listed at the start of this report.
- The recommendations contained in the L&M summary make sense, and should be followed.
- The experience of states that already have a P4P program – described in the L&M report – should be consulted to learn from their failures and successes, and to save time and money.
- The nursing facilities, their associations, and nursing industry consultants should all be integral parts of the process, which should be seen as a partnership effort. Without the support of most of the facilities, a P4P program simply won't work.
- A relatively small number of quality indicators – probably no more than three or four – should be selected to start with. To the greatest extent possible, these indicators should take advantage of information that is already being collected, to minimize the cost and administrative burden to facilities. The input of stakeholders will be especially important on this selection, but from the L&M report, Mr. Thevenot's presentation, and the earlier replies from stakeholders, it seems that some measures of both resident and employee satisfaction should be included.
- ADSA's Office of Rates Management will work with a small group including the Washington Health Care Association, Aging Services of Washington, Providence, and the Residential Care Services Division to design and implement the program. Given the short time frame, several things would need to be done simultaneously:
    - select the quality indicators to be used; get a limited, informal system producing "shadow rates" as soon as possible; and learn from that;
    - review the P4P programs in the states that currently have them, and find a model to use here;
    - file a CR 101 to start a rulemaking process, since a rule will be necessary for any money to be paid to facilities; and inquire about legislative support for an appropriation for SFY 2013.

"STRATEGIES IN PAY- FOR - PERFORMANCE"

EXECUTIVE SUMMARY

L & M Policy Research, LLC

May 18, 2011

The Washington State Legislature in 2010 directed the Department of Social and Health Services (DSHS) to contract an outside entity to both review pay-for-performance (P4P) strategies other states use in their Medicaid programs and gather stakeholder input on potential quality measures, and conduct quantitative analyses to provide a foundation for the potential implementation of a P4P program in Washington. As such, the Washington DSHS contracted L&M Policy Research, LLC, and its consultants from Brown and Harvard Universities and the University of Massachusetts Boston, Pedro Gozalo, Ph.D., David Grabowski, Ph.D., Edward Alan Miller, Ph.D., and Vincent Mor, Ph.D., to conduct a study and submit a report as outlined by the state legislature.
This report provides a summary of the study team's work. It first summarizes the current nursing home P4P experience around the country, discusses input obtained from stakeholders, and provides a quantitative analysis to illustrate the potential impact of alternative approaches to P4P program design. Finally, we present important issues for consideration as policymakers and stakeholders move forward in designing a P4P program within the Washington Medicaid nursing home reimbursement system.

Background

According to the Centers for Medicare & Medicaid's (CMS) Nursing Home Compare database, 229 nursing homes are currently operating in the state of Washington (not all of these nursing homes bill the state but nonetheless participate in either Medicare or Medicaid) – 10 of these facilities are located within a hospital, while the remaining 219 are freestanding. Just under two thirds (61.1 percent), or 140 nursing homes, are part of a multi-home system. Most nursing homes involve residents and family in decision making, with 74.2 percent of facilities operating a resident council and an additional 23.1 percent operating a council involving both residents and family. Approximately 26 percent of nursing homes operate in King County.

Study Methods

The Washington state legislature tasked DSHS with engaging consultants to answer the following research questions:

1. What P4P strategies should Washington consider for implementation in nursing homes?
2. What is the potential impact involved in implementing those strategies?
3. What factors might facilitate or impede successful introduction of P4P?

To answer these questions, the study team employed both qualitative and quantitative methods. On the qualitative side, we first updated our environmental scan of nursing home activities both in Washington and throughout the country with a special focus on P4P program initiatives. In conjunction with DSHS, the study team then identified key stakeholders that would be involved or interested in the implementation of P4P in Washington and designed multiple methods for soliciting their input. The study team developed a protocol and conducted key informant interviews to solicit similar information from a wide variety of stakeholders (22 individuals) representing single nursing homes, local and national nursing home chains, and nursing home associations. The study team conducted a second set of key informant interviews concurrently with 11 individuals involved in the implementation of P4P in nursing homes in other states: Iowa, Minnesota, Oklahoma, Utah, and Vermont. In November of 2010, the study team held the first of two stakeholder meetings, both to provide stakeholders with a sense of the nature of nursing

home P4P programs around the country and, most importantly, to solicit input should P4P be included as part of Washington state's nursing home reimbursement strategy. In order to solicit as much input as possible, the study team conducted a second meeting in the form of a Webinar, via the Internet, on January 6, 2011. Almost 300 individuals were invited to participate, including representatives of the 201 nursing homes paid by the state's Medicaid program, as well as representatives from the state's two major nursing home associations, Washington Health Care Association and Aging Services of Washington, and government representatives.

On the quantitative side, we developed a series of P4P scenarios based on a variety of weighting approaches and facility characteristics to illustrate the impact of different potential scenarios reflecting alternative approaches in the P4P program design process. Nursing home variables considered include clinical quality, staffing, inspection, location, size, and occupancy – both currently and in previous time periods – to simulate the impact of rewarding improvements, in addition to high absolute performance scores.

The team created a preliminary analytic file using the most recently available Nursing Home Compare data from 2009 and 2010 and additionally used WA DSHS January 2011 nursing home Medicaid payment rate data containing both per diem payment amounts and total Medicaid patient days. The two datasets were joined using the nursing home name, leading to a crosswalk of 201 of the 229 nursing homes. The impact analysis provides approximate broad budgetary implications.[1] We considered several alternatives to highlight the distributional implications of different possible choices and parameters that could be considered in P4P program design. When more than one measure of performance is used, the weighting of the measurement must be decided. While the indicators chosen reflect possibly policy-relevant quality measures, they are in no way indicative of all possible indicators or the product of a consensus-building exercise to develop the most important measures. They are used to demonstrate the possible implications of measurement choices Washington may make based on readily available data. Further analyses and modeling later in the process when decisions about measurement, weighting, and scoring had been made, will yield more accurate projections.

Qualitative Findings

The study team solicited input from stakeholders on 10 P4P dimensions, five of which it considered "major P4P quality dimensions" – staffing, consumer satisfaction, clinical quality indicators, survey performance, and culture change – and five of which it grouped together as "other quality dimensions" – efficiency, avoidable hospitalizations, access, "re-envisioning,"[2] and quality improvement programs. The study team also solicited input from stakeholders on key decision points, including risk adjustment, payout and budget, and eligibility and participation. Finally, the team sought stakeholder input on broad program design, adoption, and implementation issues; and it reviewed and examined patterns associated with lessons from experiences with P4P in Iowa, Minnesota, Oklahoma, Utah, and Vermont.

P4P Quality Dimensions

After asking stakeholder interviewees their background and general perspective on quality, we focused on the major dimensions of quality most frequently used in nursing home P4P programs to date – staffing, survey performance, culture change, consumer satisfaction, and clinical quality indicators. Approximately three-quarters of those interviewed favored including the clinical quality indicators in P4P; more than two-thirds favored including consumer satisfaction. On the other hand, fewer than half favored including staffing and culture change in P4P; and a little fewer than one-quarter, favored survey deficiencies.

Staffing, Culture Change, and Survey Performance. Forty-one percent of stakeholders interviewed supported including a staffing component in a P4P program; turnover and retention were believed to be particularly important measures to consider. Most stakeholders felt low turnover generally indicates greater levels of and consistency in staffing and, in turn, higher quality of care and increased employee empowerment and productivity. While stakeholders supported the idea of culture change and the broad categories of quality of life, worker empowerment, and improvements to physical plant and organizational processes, it was unclear how the dimension would be designed, how performance would be measured, and whether financial and administrative resources would be available to fund this endeavor. The current three-year transition to the new Quality Indicator Survey (QIS) system

[1] Broad budgetary implications can be drawn despite the missing values for 28 facilities, which primarily represented small facilities and those not present in both data sources.

[2] "Re-envisioning" is encouraging facilities to become a hub in a service delivery model that spans the continuum from hospitalization to post-acute care to long-term assistance, preferably at home and in the community.

was generally viewed optimistically, although it will prove to be an obstacle to using survey deficiencies as a P4P measure until the new system is in place throughout the state. This transition was viewed as important since Washington was considered by a number of stakeholders to be more punitive than other states in assigning deficiencies, and stakeholders expressed concern over tying survey deficiencies to P4P.[3]

Consumer Satisfaction. For both the stakeholders interviewed and the stakeholders polled during the Webinar, resident or family satisfaction was perceived as one of if not the most important dimension to include in a nursing home P4P program. Most stakeholder discussions focused on incorporating consumer satisfaction information in a way that is useful and minimizes the administrative and financial burden for facilities. Stakeholders considered it a direct indicator of quality care and as having a natural correlation with performance in other dimensions. Washington does not currently require facilities to administer a customer satisfaction survey; therefore, if consumer satisfaction were included as a P4P measure, the state would either need to require all facilities to adopt a standard tool, contract with a vendor, or allow facilities to use their own, either implemented in-house or through a contractor of their choice. Stakeholders expressed mixed reactions to these options, noting that regardless of whether or not a standard tool or practice is mandated for all nursing facilities, additional funding would be required for this to occur.

Clinical Quality Indicators. Stakeholders indicated that clinical quality indicators was one of the more important dimensions to include in a nursing home P4P program, with the majority of interviewees (68 percent) ranking it among the top three most important dimensions and 29 percent of poll respondents identifying it as the most important dimension. Most stakeholders believed they are a useful indicator of the quality of care patients receive, and since the data are already being collected, they should be used. Stakeholders, however, recognized that there are several complications associated with using clinical metrics, including the inability to distinguish between clinical problems acquired within the facility versus those acquired within the community or endemic to the patient population. Another concern raised involves the use of MDS 2.0 data, which some believed is not sensitive enough to be a useful indicator of performance; stakeholders expressed cautious optimism regarding MDS 3.0, feeling that it may yield more accurate and fine-tuned information.

Other Quality Dimensions. During both the interviews and the Webinar, we asked stakeholders for input on the potential importance of including other dimensions in a P4P program in the state, such as efficiency, access, avoidable hospitalizations, and presence of a quality improvement program. We also asked about the value of including a dimension reflective of state efforts to re-envision the role of the nursing home in the continuum of care or, in other words, encouraging facilities to become a hub in a service delivery model that spans the continuum from hospitalization to post-acute care to long-term assistance, preferably at home and in the community. Stakeholders expressed mixed feelings toward the efficiency dimension. Although most recognized hospitalizations are extremely costly to the health care system, they expressed concerns about using it as a measure in P4P, given challenges in defining and measuring which hospitalizations were truly avoidable. Most stakeholders either supported or were undecided about including access to care as a dimension, with few opposing it outright. Stakeholders' responses were also mixed when asked about re-envisioning as a dimension. A number of interviewees expressed reservations because they were unsure what re-envisioning meant and what, exactly, it might entail in practice.

Finally, most interviewees believed it was essential for facilities to have quality improvement plans in place, although it was unclear whether they supported including quality improvement plans or processes as a P4P dimension. Others mentioned that, should it be included as a dimension, facilities would need to demonstrate in some way not just that a plan was in place, but used in practice as part of an on-going quality improvement effort.

Decision Points

Risk Adjustment. More than two-thirds of stakeholders interviewed supported risk adjustment for certain dimensions, namely: staffing, clinical quality indicators, and possibly survey deficiencies.

Payout and Budget. Most stakeholders believed the state should ensure nursing homes receive a sufficient base payment before implementing P4P – and most supported the adoption of a provider tax as a means for funding the

[3] It is important to note that the stakeholders interviewed, as recommended by the DSHS, were primarily nursing home operators and their representatives, although the team did interview five individuals from the rate setting and survey and certification offices of DSHS.

new appropriations. In terms of the structure of the incentive, stakeholders generally preferred a fixed dollar per diem add-on followed by a percentage of the per diem rate; few commented on the option of structuring the incentive as a lump-sum payment. And most interviewees believed both absolute performance and improvement should be accounted for in P4P.

Eligibility and Participation. Most stakeholders believed participation in P4P should be voluntary, although a few interviewees asserted that changing provider behavior would instead require mandatory participation.

Design, Adoption, and Implementation Issues

When reflecting on P4P, stakeholders reported the factors they believed would facilitate or impede program implementation and adoption. Interviewees viewed favorably the fact that the existing reimbursement system is already largely performance-based with case mix and other incentives, perhaps as precedent for further incentivizing performance with P4P. Factors considered especially critical to the success of a P4P program included actively engaging a variety of stakeholders and other experts throughout the design and implementation process, improving collaboration between the state and providers, minimizing providers' administrative burdens, and emphasizing flexibility and simplicity in P4P program design and development. The majority of stakeholders also emphasized the need to keep P4P simple, enabling administrators to focus on quality improvements and policymakers to better understand the connection between spending and health outcomes.

Factors considered especially salient impediments to implementing P4P included the adverse effect of the current fiscal climate on existing reimbursement levels, the lack of evidence regarding the likely efficacy of P4P in the nursing home setting, and the potential use of administratively burdensome data collection and reporting processes. Stakeholders offered several suggestions as to the most effective means of program implementation. Several advocated taking an incremental approach to program roll-out, beginning with a more general trial period that would be followed by the phasing in of more sophisticated measures. This tactic would enable facilities to first gain experience with measurement and reporting and a deeper understanding of program goals and expectations before focusing on nuances.

Lessons Learned from Other States

A review of other states' experiences implementing P4P programs reveals several key lessons for Washington. Notably, Washington stakeholders also mentioned many of these lessons, suggesting broad support.

- Engaging a wide range of stakeholders early on and throughout the P4P design and adoption process is key to achieving buy-in for a P4P program.

- Establishing a taskforce comprised of representatives from the nursing home industry; consumer advocacy groups; and the state ombudsmen, rate setting, and survey and certification offices, among other groups, is integral to ensuring stakeholder input and consensus on an ongoing basis.

- Discussing with stakeholders the underlying philosophical underpinnings to undergird a P4P program is essential. Similarly, the state should establish meaningful measures that can be regularly refined to ensure that they adequately measure performance, and take advantage of and encourage innovations in quality assessment.

- Minimizing the administrative burden and data-collection requirements associated with the adoption of a P4P program is key. Current providers should be permitted to use existing systems to report performance when appropriate.

- Including a measure of consumer satisfaction and quality of life should be a priority despite the potential need to collect new data. There are a variety of ways to incorporate such measures that offer a range of flexibility and resource expenditures on the part of facilities.

- Funding a P4P program with new money would more likely garner support from providers and facilitate program adoption, whereas funding P4P through a redistribution of existing resources may elicit opposition and generate contention. States facing difficult budget situations have either suspended or reduced the scope of their P4P program. Others have drawn in new revenue to support their programs through a provider tax.

- Phasing in P4P slowly, beginning with performance measurement, followed by public report cards, and, finally, an introduction of P4P incentives, offers a number of advantages in terms of stakeholder acceptance and learning. Moreover, program simplicity, particularly in the early stages, can facilitate acceptance and ease administration. Similarly, ensuring flexibility in the program would allow it to evolve over time, enabling facilities and the state to gain knowledge integral to continuously improving the system.

Federal Nursing Home Value-Based Purchasing Demonstration

Beyond state P4P programs, the Centers for Medicare & Medicaid Services (CMS) launched the Nursing Home Value-Based Purchasing (NHVBP) Demonstration in July 2009 to investigate the effects of P4P within Medicare. The three-year program, implemented by Abt Associates, Inc. (Abt),[4] is taking place in three states – Arizona, New York, and Wisconsin. Abt determines the annual distribution of payments by ranking facilities based on performance scores, which are contingent on "treatment" facilities generating cost savings – relative to the performance of a comparison group in each state – through the reduction of avoidable hospitalizations and other costs (Abt Associates, 2009). The overall performance scores combine several measures and the encompassing payments are based on both performance level and overall improvement compared to other homes within each state across the three years (Abt Associates, 2009) for the following categories:

- Staffing levels and turnover (30 points),
- Avoidable hospitalizations (30 points),
- Minimum Data Set (MDS) quality measures (20 points),
- Survey domains (20 points).

All hospital-based and freestanding Medicare-certified facilities in each state had the option to enroll, which ultimately yielded 41 participating homes (31%) in Arizona, 86 participating homes (13%) in New York, and 62 participating homes (16%) in Wisconsin. A significant amount has been written about the CMS nursing home demonstration program design, including a document prepared by Abt Associates, Inc., describing the rationale for each measure selected and both the weighting and scoring for each domain.[5] While there may be interesting lessons learned through this demonstration program, the information and quality data collected during the first full operational year of the demonstration is not yet available for evaluation or consideration by the research team for this report.

Quantitative Illustrations of Alternative P4P Approaches

The research team also performed quantitative analyses. This analysis models the way a nursing home performance payment system might function within the state and highlights changes in the pool of winners as the choice of measures or measurement weight changes. The data sources and scenarios considered are unlikely to be used in a

[4] L&M Policy Research, in partnership with David Grabowski, Ph.D. and his team at Harvard Medical School, has been engaged by CMS as the evaluator of this program. Year 1 results and data for the program are expected to be available for evaluation in the summer of 2011.

[5] More information about the program and its implementation can be found at: http://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1198946.

final P4P system design; however, they detail the current environment and highlight some of the general kinds of incentives under consideration. Because we were limited to Nursing Home Compare data, not all P4P scenarios discussed or implemented in other states could be analyzed.
There are many options for the state to consider when designing a P4P incentive payment, including whether to reward absolute quality, improvements over time, or both; whether to use a composite rating, a raw percentage, a case-mix adjusted percentage, or some combination thereof; as well as which outcome measures are most appropriate on which to base payment. In addition to highlighting this range of decisions, the quantitative portion of the study demonstrates the significant effect program design may have on determining winners: Only four percent of all nursing homes were eligible to receive an incentive payment for four out of the five scenarios estimated and none were eligible for all.

It is also possible to determine a fixed number of payment incentives that will be awarded, along with a payment amount, as is the design in Vermont. In general, a payment model can be provided that will meet any budgetary goals. As discussed earlier, however, payments should be designed to provide appropriate incentives. If the payments are too small – particularly in proportion to the operational costs of implementing required changes – or too unlikely to be rewarded, there will be little incentive to change behavior to improve quality. When considering the costs of the program, policymakers should also consider the costs associated with data collection and administration.

Recommendations

Include a range of quality measures in constructing performance scores. We suggest the state rely on multiple quality dimensions to assess performance, including MDS-based quality indicators, consumer/family satisfaction scores, staffing measures, and survey deficiencies (with a minimum threshold). Single measure systems heighten the risk of unduly penalizing providers who perform well overall. Multiple measure systems, by contrast, spread the risk of poor performance across multiple quality dimensions, thereby minimizing the chances of erroneously singling out otherwise higher performing providers.

Reward facilities based on composite measure scores. The state should use the various quality measures to construct an overall quality index, as opposed to paying on individual domains of quality. That is, a nursing home's scores across multiple quality domains would be pooled to create a total composite score, with individual measures contributing to that score being assigned different weights to emphasize their relative importance. Use of a composite score approach would simplify the calculation and reporting of program outcomes. Careful attention, however, would need to be given to the weighting of the different measures, particularly if they are not correlated, as insufficient weighting could make it difficult to distinguish providers for purposes of distributing the bonuses. Absent substantial weighting, only those providers performing well below or above average on most measures would stand out.

Blend payment based on both absolute performance and improvement. In basing payment on absolute performance, nursing homes would be ranked according to their performance scores in the current period, with incentive payments being based on achieving a minimum threshold or high levels on those scores. Making rewards contingent on absolute performance would benefit already high performing providers. On the other hand, in basing payment on improvement, nursing homes would be ranked according to their level of performance relative to an earlier period as opposed to its actual level, with incentive payments being contingent on the level of improvement achieved. Rewards for improvement could encourage and help current low and medium-low performers that may otherwise have trouble initially reaching absolute-style benchmarks. Benefits from helping such low performers reach acceptable minimum levels of quality (even if just in a few key measures) may have the biggest marginal return per dollar invested in improving overall quality. The state might also consider rewarding improvement but only if actual performance exceeds a certain minimum level.

Consider rewarding high performance, not penalizing poor performance. Offer rewards to the top scoring facilities, rather than penalizing the worst performing facilities. Build in incentives for poor performers who show improvement over time.

Consider rewarding facilities on the basis of a fixed dollar add-on or bonus rather than as a percentage of the per diem rate. Dollar add-ons would be the same across all facilities, regardless of their base level of payment. By

contrast, a percentage add-on would award higher amounts to facilities with higher reimbursement rates, regardless of performance. Thus, while awards under the percentage approach would be dependent, in part, on a facility's costs, a fixed dollar add-on or bonus would exclusively reward performance.

Risk adjustment of quality measures is essential. In constructing the performance scores, adequately account for the underlying risk of residents across facilities. Otherwise, the P4P system will create incentives to admit healthier residents and restrict access to residents with complex needs.
Be as transparent as possible. Give facilities as much information as possible early on and throughout the program's operation. Be careful to balance the importance of transparency against the complexity required in providing adequate risk adjustments that need to be in place to avoid the risks of adverse selection.

Report measures/scores publicly. All measures and composite scores should be publicly reported on the state Web site. Public reporting can inform residents and discharge planners, further incentivize quality improvement by the facilities, and assist the state with the rollout of new/revised measures.

Monitor the system for potential unintended consequences. In a P4P program, facilities are only rewarded for that which is measured. There is the possibility that, if excluded, other important dimensions of quality may not receive the attention that they deserve.

If possible, use new sources of revenue to fund reward payments. To minimize risk on the part of providers, the state should use "new" dollars to fund the program rather than reallocating existing dollars. For example, one potential source of new funding would be to fund the rewards, in part, through rate increases from a future year.

In summary, P4P programs can be designed in a variety of different ways, and there is no single design that has been demonstrated to achieve the best outcomes. Washington's Medicaid nursing home reimbursement system already rewards performance in several areas. Prominent examples include case-mix adjustment, the exceptional care rate add-on, and the state's current P4P initiative which rewards/penalizes facilities achieving low/high direct care staff turnover. The purpose of this report was to explore the possibility of adopting a much more comprehensive pay-for-performance program that accounts for facility performance in a variety of areas. With this in mind, Washington has a lot of flexibility to make the choices that work best for its particular environment.

When identifying the best design, the state must first bring key stakeholders together to determine the underlying philosophy and principles that will guide design and implementation of the program. As the state discusses the underlying principles of the P4P program design, it should consider focusing on rewarding high performance rather than penalizing poor performers. A second step will be to canvass the possibilities in terms of the quality measures and P4P domains, recognizing the key decision points in question. The state should consider including a range of quality measures when constructing performance scores. Obtaining input from those involved in quality measurement both within facilities and from the state will be critical, as will careful assessment of the potential up and down sides of given design choices. The use of multiple quality measures that result in a composite score that is appropriately risk adjusted will be critical to the P4P program's success. Experience in other states suggests that the system would be best phased in over time to give both facilities and the state time to learn and refine the program, and that the system should reward both absolute performance and improvement. Regardless of what system is adopted, the state should consider using new sources of revenue to fund reward payments. In an effort to make the system as transparent as possible, the state will benefit from making the measures public so facilities and consumers can see the relative rankings and use this knowledge to inform their operational and care decisions moving forward. As with any new payment system, monitoring for potential unintended consequences as well as conducting annual assessments of the program successes and potential improvements moving forward will be important.