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Pay-for-Performance in Five State Medicaid Programs: Lessons for the Nursing Home Sector

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Background

- The federal government has traditionally sought to ensure quality outcomes through nursing home (NH) surveys conducted by state officials.
- Some states have begun to experiment with pay-for-performance (P4P) incentives, which provider higher Medicaid reimbursement to those facilities achieving desired outcomes.
- By 2007, there were 9 state P4P programs covering 20% of NHs and 16.7% of residents.
- Little is known about the use of P4P to promote quality and efficiency in the NH sector.

Study Objective

- To draw lessons for the successful development and implementation of P4P incentives from their use in five diverse Medicaid NH programs: Iowa, Minnesota, Oklahoma, Utah, and Vermont.

Methods

- Data derived from archival sources and interviews with state agency officials.
- Interviews were conducted with 11 individuals from 12/16/10 to 1/7/11.
- Selection of respondents was based on which individuals were most knowledgeable about each state's P4P program.

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Methods-Continued

- Transcripts were coded to identify recurring themes and patterns in responses.
- Documents were used to cross-validate informant responses and to provide background.

Findings

Participation

- States should obtain stakeholder input, both initially and on an ongoing basis.
- States should establish taskforces comprised of NH industry representatives; consumer advocates; rate setting, survey/certification, and other state staff; and other interested parties.

Financing

- States should consider using "new" dollars to fund P4P rather than reallocating existing dollars.
- States should consider devoting a portion of a planned rate increase toward funding P4P.
- States should consider funding P4P through provider taxes, which draw in additional federal dollars without increases in state expenditures.

Measurement

- Incorporating too many quality dimensions can dilute program effectiveness; additional measures can be added as a program matures.
- Commonly used dimensions include staffing, satisfaction, survey performance, clinical quality indicators, and person-centered care.

Findings-Continued

Administration

- States should focus on minimizing administrative burdens and data collection requirements.
- Providers should be permitted to use existing systems to report performance where possible.

Development

- States should phase-in P4P, beginning with measurement, followed by public reporting, and then linking payment to facility performance.
- States should build flexibility into P4P program design to take advantage of new knowledge integral to improving program effectiveness.

Implications

When canvassing possible P4P options, states should first bring key stakeholders together to determine the underlying philosophy and principles that will guide program design and implementation. Once adopted states should monitor for unintended consequences, and conduct periodic assessments to identify program successes and potential areas for improvement.

Dissemination

- Produced/distributed report for Washington State Legislature. For additional information, see: http://www.adsa.dshs.wa.gov/professional/rates/reports/.