Better Jobs Better Care

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?

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This paper was written by Debra J. Lipson, Deputy Director of the Better Jobs Better Care National Program Office at the Institute for the Future of Aging Services, American Association of Homes and Services for the Aging. She has over two dozen years of experience as a health policy analyst and program manager at the local, state, national and international levels. Her areas of expertise include Medicaid financing, state programs for the uninsured, and the long-term care workforce, in addition to issues at the nexus of international trade and health. She holds a masters degree in health services administration from the University of Michigan, School of Public Health.

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## 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.