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ISSUE BRIEF

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STATE USE OF VALUE-BASED PAYMENT IN NURSING FACILITIES

KEY POINTS

- Twenty states and the District of Columbia (DC) use value-based payment (VBP) as part of their nursing facility Medicaid payment system.
- Most state nursing facility VBP programs include mandatory participation on the part of providers; only California, Colorado, Texas, and DC have voluntary programs. Kansas and Minnesota have both voluntary and mandatory programs.
- Only the voluntary VBP programs in Kansas and Minnesota have been formally evaluated. Lack of program evaluations hinder states' ability to learn from programs already implemented in other states.
- Stakeholders noted that VBP programs are more successful if they include risk-adjusted, clinically meaningful measures.
- Clinical measures are most often used in state VBP programs, followed by staffing measures, and resident and family satisfaction measures.
- Nursing facilities may need technical assistance to participate in VBP programs and achieve meaningful changes in quality or costs.

INTRODUCTION

Some states use value-based payment (VBP) or pay-for-performance (P4P) programs as part of their nursing facility Medicaid payment systems. Yet, little is known about these programs. The purpose of this study was to determine which states use these programs, their goals, the measures used, and other elements of these programs. We found that 20 states and the District of Columbia (DC) use VBP for nursing facilities with the goals of improving quality and increasing efficiency. However, due to lack of evaluation, it is not known if these programs are achieving their goals. Additional research is needed to determine which state programs are most successful. The results of such research would help in the development of future VBP programs.

Payers across the health care spectrum have begun transitioning from paying for quantity toward paying for quality. These VBP programs vary in scope and focus, but generally share the goals of improving cost-savings and linking payments to value rather than volume. At the federal level, the U.S. Department of Health and Human Services (HHS) has increased efforts to promote VBP by setting targets for their use by all payers. In 2015, HHS set the goal of tying 30% of traditional Medicare payments to quality or value by 2016, and 50% by the end of 2018. Progress towards these goals varies widely by health care sector and payment source (i.e., commercial or public).[1]

Although Medicare payments for hospital and skilled nursing facility care are tied to performance via mandatory national VBP programs, nothing on a national scale has been implemented to date for Medicaid-covered nursing facility care. Many states have implemented P4P methodologies, a type of VBP program that provides payment incentives to nursing facilities for achieving certain goals (e.g., meeting quality measure benchmarks). States using VBP and P4P programs vary widely in terms of how performance or quality are

measured--some states use existing measures whereas others have developed their own. They also vary as to whether participation is mandatory or voluntary.

Little is known about how VBP programs for Medicaid-covered nursing facility care are designed, the specific goals states are trying to achieve with these, or whether they are successful in achieving their stated goals. This exploratory study sought to answer the research questions shown below.

Research Questions

1. Which states use value-based purchasing programs as part of their nursing facility Medicaid payment?
2. What are the goals of VBP programs and have states achieved their goals?
3. What are the key elements of VBP programs?

METHODS

An environmental scan was conducted to identify states that have VBP programs for nursing facilities, the key design elements of those VBP programs, and the goals that states are aiming to achieve through these programs. The scan included a review of state websites and peer reviewed and gray literature. All 50 states and DC were included, but United States territories were not. The information gathered was organized by state in a spreadsheet.

Interviews with seven stakeholders were also conducted: five with Medicaid representatives in states with VBP programs (Colorado, Kansas, Maryland, Minnesota, New York), one with a national industry association representative, and one with an academic researcher with expertise in VBP. Key themes were identified across interviews.

LIMITATIONS

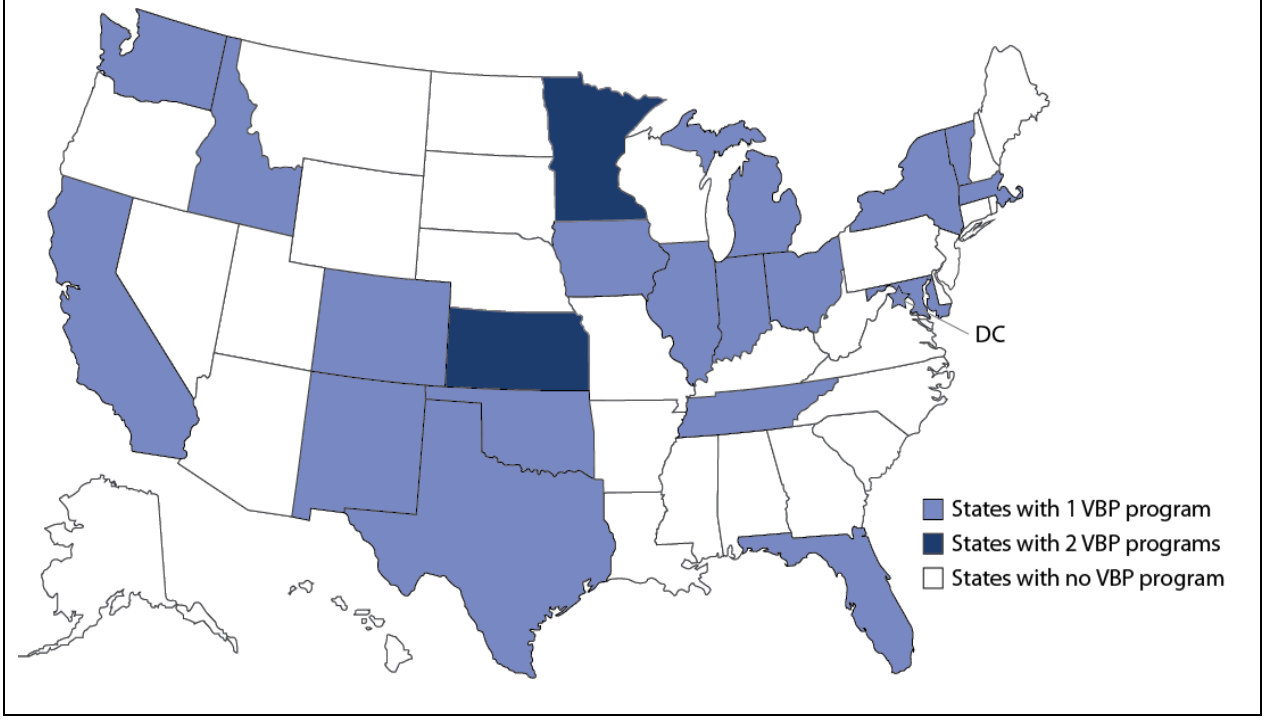
The environmental scan was limited to information that is publicly available about state nursing facility VBP programs and did not include a formal analysis of state legislation or discussion with state representatives. This may have limited the information we were able to find about these programs. For example, some states only make available the types of measures used in their program and do not list the actual measures used. Our stakeholder interviews are not generalizable and included only five of the 20 states (and DC) with VBP programs. State representatives that agreed to participate in these interviews may have been different from those who did not participate. For example, state representatives may have been more willing to participate if they viewed their VBP program as successful, which may have limited the information we were able to collect about less successful programs. In addition, some state representatives we spoke to were not in their positions when the VBP program was developed and were unable to provide details about why or how the program was developed.

RESULTS

Which states use VBP programs as part of their nursing facility Medicaid payment?

As shown in ***Exhibit 1***, as of November 2021, 20 states and DC use VBP programs as part of their nursing facility Medicaid payment. Two states (Minnesota and Kansas) have two VBP programs each.

Exhibit 1. States with Value-Based Purchasing Programs for Nursing Facilities in 2021



What are states' goals for VBP programs, and have states achieved these goals?

Goals and Evaluation

Stakeholders reported that states are using VBP in nursing facility payment policy to improve quality and reward high performance, increase efficiency and value, and sometimes to promote best practices and educate providers. It is unclear whether VBP programs have achieved these goals because most programs have not been formally evaluated.

> *"With the quality [measure] components, [evaluation] is a little bit harder because those are, they're multi-factorial."*
> *- State representative*

Lack of program evaluations hindered states' ability to learn from programs already implemented in other states. Experts noted that these programs are difficult to evaluate and rarely are because states do not have the resources to conduct evaluations. However, the voluntary programs in Minnesota and Kansas have been evaluated by academic researchers. The evaluations measured the effect of the programs on quality but did not examine changes in costs. An evaluation of Minnesota's voluntary program, funded by the HHS Agency for Healthcare Research and Quality, found that participating facilities significantly improved their quality scores, while non-participating facilities did not show significant improvement.[2] Participation in Kansas's voluntary program, which is focused on the adoption of person-centered care (i.e., culture change practices), was associated with better clinical outcomes for seven of 13 minimum data set (MDS) 3.0 long-stay resident health measures.[3]

Stakeholder Suggestions for Achieving Goals

Most stakeholders said that VBP programs are more successful if they include risk-adjusted clinically meaningful measures that can be updated as needed. Some suggested that measures should be oriented toward outcomes rather than processes. Some also suggested that programs should use a limited number of measures; too many measures could be burdensome and might make it difficult for facilities to determine

where to best invest their efforts. An industry stakeholder suggested that, based on research his organization was conducting, roughly five measures was optimal.

Stakeholders thought that VBP programs were less successful when they included benchmarks that were difficult to achieve or that were not meaningful, or when they did not consider the variability introduced by certain factors--like differences in resident population across facilities that cannot be fully controlled for in statistical models.

> *"Providers want to know if I spend my money and invest here, they want a clear path that the outcome is going to benefit them."*
> *- State representative*

Some stakeholders noted that programs could be administratively burdensome and too complex for nursing facilities to understand and implement. Some suggested that nursing facilities may need technical assistance to participate or achieve meaningful change.

> *"Some nursing homes are going to need more technical assistance or maybe even financial investment to be able to invest in the infrastructure that's needed to improve quality of care."*
> *- Academic researcher*

Stakeholders noted that industry representatives were often involved in developing or updating VBP programs and suggested that this was important for buy-in to the program. Some noted that nursing facilities do not like these programs when they include measures of things that may be out of their control, when there is downside risk, and when funds (such as provider taxes or withholds) paid into the program cannot be earned back.

What are the key elements of VBP programs?

Eligibility

Most nursing facility Medicaid VBP programs are mandatory; only three states (California, Colorado, and Texas) and DC have voluntary programs. The two states with two VBP programs (Minnesota and Kansas) each have one mandatory and one voluntary program. A stakeholder from Minnesota noted that the reason their state has two programs is to provide some balance between only rewarding high performers and providing funds to low performers so that they have a chance to improve. An industry stakeholder noted that Minnesota can do this because they have dedicated a lot of infrastructure to their voluntary program that other states may be unable to provide.

There was disagreement among stakeholders about whether voluntary or mandatory programs are more successful. Some thought that voluntary programs encouraged better performance, whereas others thought that voluntary participation made it difficult to attract providers to participate or only attracted those facilities that were already high performers.

Some states limit eligibility for their programs to certain types of facilities. For example, in Ohio, facilities with less than 80% occupancy are excluded. Several states exclude facilities based on previous issues with quality, such as special focus facilities or facilities with a certain number or type of survey deficiencies. One stakeholder disagreed with the use of these types of "gatekeeper" measures, saying that they put too much weight on one type of quality measurement for eligibility.

Measures

In many cases, state regulations specify only the types of measures used, rather than the exact measures. That may allow states to more easily change the measures used in their program as quality goals are achieved or data for measures become unavailable. The types of measures used include annual survey derived measures

(e.g., number of deficiencies), measures of facility culture change practices (e.g., resident choice of bath time), resident and family satisfaction measures, staffing measures (e.g., staff retention rates), and clinical measures.

Clinical measures are the most commonly used measures in state nursing facility VBP programs, followed by staffing measures, and resident and family satisfaction measures. Clinical measures include those developed by the HHS Centers for Medicare & Medicaid Services from MDS data. Some states have also developed their own clinical measures, such as rates of hospitalization. Only six measures are used by six or more states. These are shown in ***Exhibit 2***. All other measures are used by three states or fewer indicating wide variety in the measures used across states.

> *"I don't like gatekeeper metrics… Basically, what that means is you've said that that measure is more important than any of the other measures."*
>
> *- Industry representative*

Exhibit 2. Most Used Measures in State VBP Programs for Medicaid-Covered Nursing Facility Care

Most Used Measures in State VBP Programs for Medicaid-Covered Nursing Facility Care Measure	Number of States Using Measure
Urinary Tract Infection Incidence	14
Pressure Ulcer Incidence	14
Antipsychotic use	11
Resident Satisfaction	9
Staff Retention	7
Physical Restraint Use	6

Financing and Payment

States pay for their VBP programs in various ways, such as Medicaid general funds, nursing facility provider taxes (i.e., bed taxes), and monies from administrative penalties. Facilities receive payments either as supplemental payments paid yearly, quarterly, or monthly, or as add-ons to the Medicaid per diem rate. In all states except New York, nursing facilities do not face any downside risk in that they do not lose money if they do not meet program goals. The VBP program in New York is funded through a Medicaid payment withhold, and the poorest performing facilities do not receive their withheld payments.

CONCLUSION

This was a study to explore states' use of VBP as part of their Medicaid nursing facility payment, including the goals of such programs, the measures used and other key elements. Twenty states and DC use VBP as part of their Medicaid nursing facility payment. States vary in terms of the types and number of measures used in the programs, how programs are funded, and how facilities are paid. But the goals of these programs--to improve quality and efficiency--are fairly consistent across states.

One purpose of this study was to determine whether state VBP programs for nursing facilities are achieving their goals. However, this was not possible due to lack of rigorous evaluation. Most state stakeholders reported not knowing if their programs were working as intended, and only two programs have been formally evaluated. The primary reason for this lack of evaluation is that states do not have the resources needed to conduct evaluations.

This lack of evaluation seems to result in states developing programs without critical insights that could be learned from previously established programs in other states. There is very little information available to state staff regarding what has worked in other states and what has not. Therefore, an important next step in this area is a formal evaluation that would determine whether these VBP programs are improving quality and increasing efficiency. Future research could evaluate these programs and determine which state programs are most successful at improving quality.

Any future research would have to take into consideration that each state's program is targeting different aspects of quality and measuring these in varying ways, and that different states have been utilizing VBP for different lengths of time. Therefore, a two-pronged approach should be taken to: (1) compare quality in states with VBP programs to states without these programs; and (2) evaluate the impact of VBP programs within states. This type of evaluation would determine both the success of VBP programs overall and identify those states that have been most successful. Additional in-depth evaluation of the design, measures used, and other elements of these successful VBP programs would provide valuable information to other states designing new VBP programs or those redesigning existing programs.

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Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

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ABOUT THE AUTHORS
Denise A. Tyler, Ph.D., Kristie A. Porter, M.P.H., and Natalie Mulmule work at RTI International.

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