MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

# COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

## Pay for Performance Application Review

## Recommendations Report

## State Fiscal Year 2016-2017

DEDICATED TO GOVERNMENT HEALTH PROGRAMS

# *Colorado Pay for Performance Recommendations Report*

# *Report Overview*

Myers and Stauffer was pleased to work with the State of Colorado Department of Health Care Policy & Financing (HCPF, or the "Department") on the 2016 Pay for Performance (P4P) application reviews. This report provides our recommendations for future iterations of the P4P program. Through the course of the review process our staff made many observations about the P4P program and how it could be improved. We also took time to investigate P4P programs in other states to gather information on different approaches to value-based payments. Finally, we reviewed the Centers for Medicare and Medicaid Services (CMS) P4P initiatives. We combined our observations from each of these steps to develop the recommendations included in this report.

# *Observations from the Application Review Process*

Throughout the application review process Myers and Stauffer made several observations that lend insight into the Colorado P4P program and in many cases provide clear opportunities for improving the program. Many of these observations cover administrative processes and application requirements, while some related to the outcomes of the review process. This section of the Recommendations Report summarizes these observations.

**Administrative Processes and Applications Requirements**

The first observation we made was that the applications were submitted in various formats and by multiple methods, leading to inefficiencies in processing the applications. Some applications included documentation that was submitted as Microsoft Word documents, some were submitted as PDF documents, and others were submitted as Power Point presentations. Many applications were submitted in hard copy format, generally in large binders, via U.S. Mail or other parcel delivery services. Some providers chose to prepare and submit their applications on flash drives or compact discs (CD). Still other providers used the web portal we established or sent their application in by email.

The variations in how the applications were prepared and submitted created many administrative challenges. Tracking the receipt of the applications was cumbersome due to the different submission methods. Hard copy files were scanned so that they could be stored in the electronic file management system we utilized for the review process. Some of the electronic files we received also had to be manipulated before they could be saved into the file management system due to file size or file naming conventions. Finally, applications that were submitted as hard copies had to be entered into Excel so that the electronic version could be uploaded to the web portal.

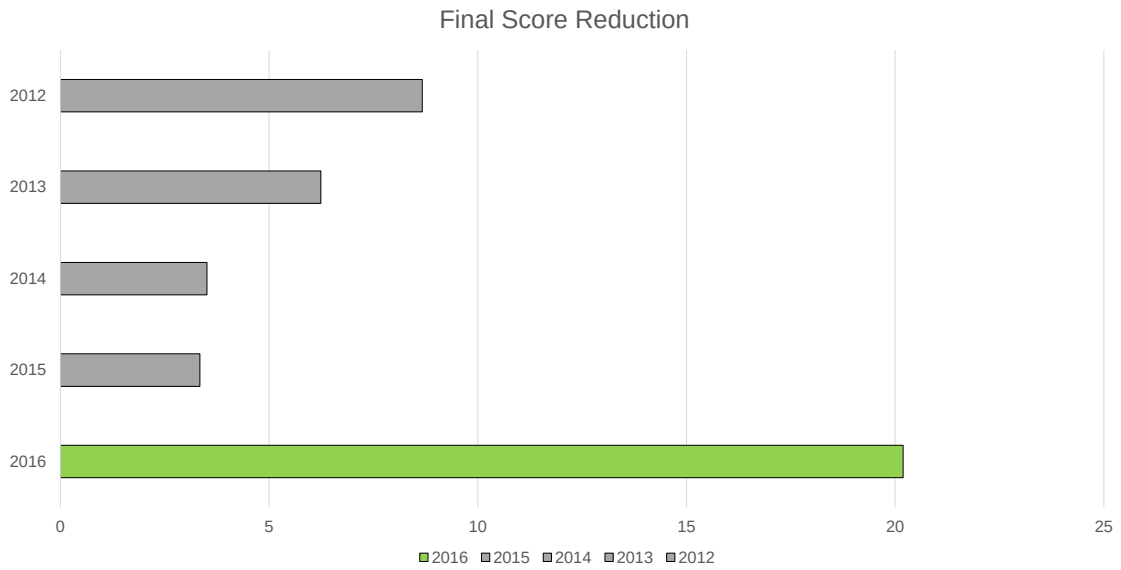
Another administrative concern is the integrity of the application itself. The initial application that was distributed to providers contained some formula errors, was missing a worksheet, and included some information that pertained to last year's application. These issues were resolved but also created some inefficiency in processing the applications.

**Recommendation 1**

To improve the administrative efficiency of the P4P program, we recommend that the Department standardize the format and submission of the application and supporting documentation. This should include the requirement that the application and all supporting documentation be submitted electronically preferably through a web portal. The application itself should be submitted using an Excel file template that is maintained by a designated custodian, preferably the application review contractor. The Department should also require that all supporting documentation be submitted in a specified file format such as PDF. Each applicant should also be required to submit their application and supporting documentation in a specified organization perhaps outlined by a checklist within the application. Taking these simple steps would drastically improve the administrative efficiency of the program.

**Review Process Outcomes**

One of the most startling outcomes of the review process was a significant change in the scoring adjustments made to the provider's final score. On average, our review team reduced the applicant's self-score by 20.19 points. This was in stark comparison to the average adjustment from the previous four years that ranged from 8.67 points in 2012 to 3.34 points in 2015. The table below shows the average final score adjustment for each of the last five years. Note that 2016 results do not consider score revisions due to appeals. However, they do include scored measures for the seven facilities not meeting the prerequisite discussed further in this report.




The significant change in scoring reductions is likely attributable to more than one factor. To start with, we strictly adhered to the application requirements and disallowed points that providers awarded to themselves but failed to clearly document according to the application guidelines. Although providers were often surprised by our disallowances they generally agreed with our findings and in most cases seemed to come away with a better understanding of the application requirements and the P4P program objectives. In addition, changes to one of the prerequisites as well as added or revised minimum requirements for a few measures contributed to either a final score of zero or the loss of points.

An example that illustrates how we strictly adhered to the application requirements is the Resident/Family Satisfaction Survey application prerequisite. Prior to 2016, the application requirements merely stated that these surveys must be completed by an outside entity and that they must occur during the calendar year of the application. The 2016 application is the first instance where a specific number of responses were required. The response rate must be equal to at least 25% of the average daily census. Six facilities did not meet this prerequisite as their number of responses did not represent 25% of their average daily census. One home's survey did not specify the outside entity that conducted the survey. These seven facilities are listed below. Myers and Stauffer scored their application and sent the results along with a notification that the home would receive a score of zero points. The appeal rights remained intact for these facilities. If they were able to clarify their survey, they were also able to appeal

the measure scores of their application as well. Note that none of the facilities listed in the chart below filed an appeal.

| Provider Name | Provider Number | Self Score | Reviewed Score |
|---|---|---|---|
| Centura Health - Medalion Health Center | 05650304 | 47 | 38 |
| Forest Street Compassionate Care Center | 00122777 | 52 | 26 |
| Garden Terrace Alzheimer's Center | 05653043 | 23 | 2 |
| Life Care Center of Colorado Springs | 05652680 | 38 | 32 |
| Sharmar Village Care Center | 05652540 | 55 | 8 |
| Villa Manor Care Center | 05655709 | 78 | 25 |
| Westlake Care Community | 05655410 | 83 | 55 |

Another factor that contributed to the reduction in the average final score is that many measures contained extensive and/or confusing language that the applicants frequently misinterpreted. The Quality Assurance Performance Improvement (QAPI) measure is an example of a measure that includes some extensive/confusing criteria. We removed points for 72% of the providers that applied for points from this measure. A portion of the language included for this measure is below. This minimum requirement is also a new addition from the prior year application.

> Submit documentation for at least one data-driven Quality Improvement Project, including associated education and at least three Quality Improvement Cycles. Include evidence that staff, residents and their families as able are aware of and have the opportunity to support the QI project. The home is kept informed of the project and progress (including trend graphs) through storyboards.

There are several aspects of these requirements that providers interpreted in different ways but that could easily be clarified to encourage more consistent reporting. What constitutes “associated education” is not defined and the way in which the provider documents it can vary considerably. The period that denotes a “Quality Improvement cycle” is also not defined and again the documentation that providers choose to submit could vary widely. Finally, the requirements “that evidence that staff, residents and their families are aware of” the initiative and the “home is kept informed of the project” do not provide clear guidance as to what documentation will be accepted. In each of these cases additional information could be provided to clarify what is expected.

There are also several cases in the application where definitive language is not used but instead providers are told they may or should include something. Sometimes such vague wording is used in conjunction with clear requirements. This type of wording lends itself to interpretation, leaves the provider uncertain about what is required, and makes evaluating the applications more subjective. An example of some wording like this is below.

> Details on how residents and staff of all disciplines can support the project must be included in this communication, and the storyboard should include updated trend graphs of your progress. Your documentation may include photos of the storyboard, templates, resident meeting minutes or other material.

Suggestions for what supporting documentation "can" include are also stated as the last item within the minimum requirements. Also, phrases like "Please" or "Please be sure to" precede a submission requirement, suggesting that the requirement is optional. These instances may also leave the provider uncertain about what is required. While these general observations do apply to several measures, it should be noted that the application is very thorough and does often specify exactly what is required of the applicant. The all or nothing approach to earning points for each measure is also helpful in that it removes the need for rating a response when it meets some but not all of the criteria for a particular measure.

### Recommendation 2

To address these issues we recommend that vague language be revised in the application and that some provider outreach and education be conducted so that applicants have an opportunity to be better informed. The documentation requirements for each measure should be clearly defined by concise criteria. Suggestions for acceptable documentation should be placed in an appendix or an FAQ document. Definitions of terms used in the application, such as "home décor" should also be clarified. Once the application has been finalized each year, training presentations should be made to explain changes to the application from previous years. This training should also review the evaluation and documentation requirements for each measure regardless of whether it has changed or not.

**Applicant Administrative Burden**

Some members of the provider community have stated that the application documentation required is administratively burdensome. Areas exist where the documentation requirements should be revised.

One example is requiring the provider to submit a copy of their Colorado Department of Public Health and Environment (CDPHE) state survey with their application. The prerequisite states that no home with substandard deficiencies, as defined in the State Operations Manual, during the previous calendar year may apply. The application then further states that this prerequisite will be obtained and verified with CDPHE, however, requires the provider to initial verifying that a copy of their survey is included. For the 2016 application, Myers and Stauffer received a spreadsheet with stated deficiencies from the Department and independently verified that each applicant met the prerequisite. The copies of each state survey were filed in each provider's respective engagement binder. However, they did not serve a purpose as they were not reviewed.

A second example is implementing the two stage application process described in Recommendation 5 below. If implemented, this would alleviate the provider of submitting:

- CASPER reports for Nationally Reported Quality Measure Scores
- CASPER reports for the Quality Measure Composite Score
- Trend Tracker/Advancing Excellence reports for Reducing Avoidable Hospitalizations
- Annual census data for Medicaid Occupancy Average

### Recommendation 3

Do not require applicants to submit a copy of their CDPHE survey for the calendar year under review. In addition, adopt Recommendation 5.

**Application Design**

Several providers submitted documentation from years other than the calendar year under review (2015), including resident wishes documentation, care plans and pictures. Some documentation was submitted from as far back as 2009 while some from 2016 was submitted. It is feasible, though not verified, that the same documentation has been submitted year after year for some measures. Our understanding of the Pay for Performance program is that minimum requirements must be met during the calendar year applied for, not before or after. The application should clarify the time-frame of acceptable documentation to produce more relevant and current information.

Creation of formatted cells within the application where providers enter data would produce a more consistent response level for certain measures. For example,

- Consistent Assignments – cells for 4th quarter 2014 and 4th quarter 2015 home wide average
- Continuing Education – Reference the Final Report for extensive application revision suggestions to Appendix 2 and Appendix 3
- Staff Retention and Staff Retention Improvement – cells in the Appendix 4 calculation
- DON and NHA Retention – cells for hire date and date started in position with an automatic retention period calculation
- Nursing Staff Turnover Ratio – embed Appendix 6 in the application since the calculation is simplistic. Create cells for components of the calculation.
- Staff Satisfaction Survey Response Rate – cells for response rate for each of the two categories

**Recommendation 4**

The application should specify that only documentation dated January 1st through December 31st of the calendar year under review should be submitted with the application, including testimonials, pictures, resident care plans and end of life wishes. Standardized entry cells should be created for specific measures to create clarity and increase participation.

**Applicant Participation Level**

The chart below outlines the participation rate since the program's inception.

| | Calendar Year 2008* | Calendar Year 2009* | Calendar Year 2010* | Calendar Year 2011 | Calendar Year 2012 | Calendar Year 2013 | Calendar Year 2014 | Calendar Year 2015 |
|---|---|---|---|---|---|---|---|---|
| Number of Applicants | 40 | 111 | 100 | 117 | 119 | 127 | 125 | 129 |
| Participation Rate** | 21% | 58% | 53% | 62% | 63% | 67% | 66% | 68% |

* Estimate based on number of on-site visits.
** Based on 190 approximate number of homes

The participation rate remains consistently within the 60% percent range for the last five years. Although this is impressive for a voluntary program, a 100% participation rate is possible.

A two stage process should be adopted in scoring Pay for Performance. The first stage, or Phase I, would consist of scoring all facilities on mathematically based scoring measures by

obtaining reports through the Department or its vendors for all Class I facilities and automatically scoring them. The measures suggested for Phase I include Consistent Assignments, Reducing Avoidable Hospitalizations, Nationally Reported Quality Measures, Quality Measure Composite Score and Medicaid Occupancy Average. Only one of the prerequisites will apply, the requirement that the home receive no substandard deficiencies on their state survey for the previous calendar year. All facilities would be scored. However, only those without a substandard deficiency would receive a payment. Benefits of this suggested approach include receiving consistent comparable data for the entirety of Colorado's homes, allowing for more directed and insightful committee and policy decision making as well as achieving a 100% participation rate. Note that for Consistent Assignments, the minimum requirement of submitting a detailed narrative would need to be eliminated in order to make this measure purely numbers based. If 21 points is achieved, the home would be achieve a per diem rate add-on of $1.00 per the tiers established in regulation. However, as seen in the chart below, the home would not achieve more than $1.00 unless they submitted an application and associated documentation to receive the remainder of the 60 possible points described in Phase II.

| Application Measure | Data Source | 2016 Points Possible |
|---|---|---|
| Consistent Assignments | Advancing Excellence | 6 |
| Reducing Avoidable Hospitalizations | Trend Tracker or Advancing Excellence | 3 |
| Nationally Reported Quality Measures | | |
| *Residents with One or More Falls with Major Injury* | CASPER Reports | 1-5 |
| *Residents who Self-Report Moderate/Severe Pain(L)* | CASPER Reports | 1-5 |
| *High Risk Resident with Pressure Ulcers(L)* | CASPER Reports | 1-5 |
| *Residents with a UTI* | CASPER Reports | 1-5 |
| *Residents who Received Antipsychotic Medications* | CASPER Reports | 1-5 |
| Quality Measure Composite Score | CASPER Reports | 1 |
| Medicaid Occupancy Average | Myers and Stauffer | 3 or 5 |
| **Grand Total** | | **40** |

The second stage, or Phase II, is optional and dependent on the voluntary participation of the home. The remainder of the 60 possible points may be obtained if the second prerequisite is met and the home submits an application and supporting documentation for the measures they wish to apply for. The second prerequisite of the Resident/Family Satisfaction Survey must meet the designated number of responses before the application is accepted and scored.

### Recommendation 5

A two stage process should be adopted to increase the Pay for Performance participation rate to 100%. Phase I would score mathematically based measures for all homes based on consistent documentation received directly from the Department or its vendors. Phase II is optional for homes that want to apply for the remaining available points. The Department's contractor will perform calculations for Phase I, review applications for Phase II, then combine scores from Phase I and Phase II to achieve a total final score.

# *Pay for Performance Programs in Other States*

Many states have incorporated pay for performance initiatives into their Medicaid nursing home reimbursement programs. Myers and Stauffer works with some aspect of the Medicaid nursing home reimbursement program in approximately twenty different states. This gives us intimate insight into many pay for performance programs around the country. Myers and Stauffer leveraged this privileged access to evaluate state P4P initiatives and sort out those programs that might provide Colorado with new insight. This section presents an overview of three state's P4P programs and makes recommendations for how Colorado might incorporate aspects of other state programs into its own P4P program.

**Indiana**

Indiana began its move towards value based payments (VBP) in 2003. That year the state implemented a Report Card Score Add-on ranging from $1.50 to $3.00. Each home's report card score was based on their performance on survey inspections, staffing, and quality of life measures. The original report card score had an inverse relationship to the per diem add-on. The lower the score the higher the per diem add-on. Under the initial program homes with a score between 0-50 received a $3.00 add-on, facilities between 51-105 received $2.50, those between 106-200 received $2.00, and providers with a score over 200 received $1.50. Any home that did not have a report card score received a $2.00 per diem add-on.

For July 1, 2010 the ranges were revised and the scoring was moved to an annual process with updates every June 30th. The ranges were reset so that the top tier included facilities with scores from 0-82 and those facilities received $5.75 per day. The bottom range included those providers with scores of 266 or higher and they received no ($0.00) add-on. The facilities that fell between 83 and 265 received a prorated add-on determined by a formula that incorporated their Report Card Score. This formula is given below and resulted in providers receiving a higher per diem add-on (up to $5.75) the closer they were to a Report Card Score of 82.

***Add-on Formula for Scores 83-265 Effective July 1, 2010***

***Per Diem Add-on = $5.75 – ((Report Card Score – 82) x $0.03125)***

On October 1, 2011 the maximum per diem add-on was increased to $14.30. The ranges were kept the same with the top tier still including homes that scored 82 or less, and the bottom range including those homes that scored 266 or more. The formula for the middle range (83-265) was also updated to reflect the higher maximum add-on.

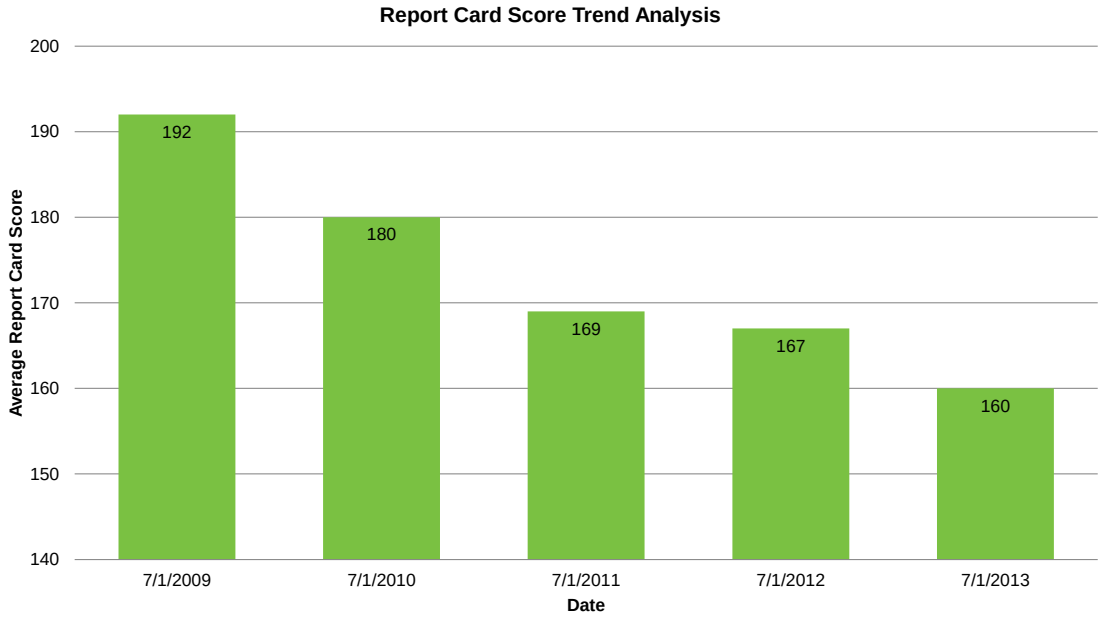
***Add-on Formula for Scores 83-265 Effective October 1, 2011***

***Per Diem Add-on = $14.30 – ((Report Card Score – 82) x $0.07777***

The increase in the maximum add-on resulted in a more meaningful amount of funding tied to quality incentives. The maximum add-on of $14.30 per day amounts to as much as 12% of the

Medicaid daily rate. The total state expenditures tied to incentive payments is now approximately $110 million.

Even before the state increased its commitment to value based payments, Indiana observed a decrease in the average Report Card Score (again the lower the score during this phase the better). The average score dropped from 192 in 2009 to 160 in 2013. The table below illustrates this trend.




The measures that are included in the Indiana Report Card Score were established through negotiations between the Indiana Division of Aging Office of Medicaid Policy and Planning and representatives of the nursing home industry. A Clinical Experts Panel was formed in 2010 to analyze data and make recommendations for the measures and the scoring methodology. These recommendations were debated through the negotiations process and resulted in the addition of several new measures and revisions to the scoring methodology.

Effective July 1, 2013 Indiana implemented a new scoring system for its performance measures. The score is now called the Total Quality Score and it is based on a 100 point scale. It incorporates the previous Report Card Score and all of its related measures. The scoring ranges are also flipped now so that the top tier is limited to facilities with a score of 84 or higher. The bottom tier is for providers that score 18 or less. Per diem add-ons for the middle tier are now determined by an updated formula given below.

***Add-on Formula for Scores 83-265 Effective July 1, 2013***

***Per Diem Add-on = $14.30 – ((84 – Total Quality Score) x $0.216667)***

Indiana began a new phase (Phase 4) of its program February 27, 2015. This phase will follow the same process to negotiate changes to the measures and scoring methodology utilizing the Clinical Experts Panel to produce recommendations. Those recommendations will then be

negotiated between the state and industry to determine actual scoring and reimbursement parameters.

The measures that Indiana uses for its Total Quality Score cover a very broad range. They include staff hours for registered nurses (RN), licensed practical nurses (LPN), certified nursing aides (CNA) and other staff, each of which are evaluated separately. The state also applies a case mix adjustment to the staffing data. Staff retention and staff turnover are evaluated as separate measures for RN/LPN, CNA, administrators, and directors of nursing (DON). The measures that were used in the initial version of the Indiana quality add-on program (Report Card Score) are still used. They include performance on survey inspections, staffing, and quality of life measures.

Another unique aspect of the Indiana program is that funding for the Indiana nursing home P4P program is derived through a provider tax. This funding is used to leverage federal dollars through a supplemental payment program. Indiana also utilizes an intergovernmental transfer (IGT) program to reduce its state funding burden. Over 80% of the providers in Indiana participate in this IGT program. Many of these providers have qualified for the IGT program by undergoing an ownership restructuring arrangement that enables them to be classified as a non-state governmental entity.

### Recommendation 6

Colorado should consider implementing a prorated quality add-on similar to the Indiana model. Such a model makes every point in the quality rating score valuable and in the Indiana experience this seems to have motivated providers to pursue improvements that have resulted in better quality scores across the state.

### Recommendation 7

The high per diem and the use of the IGT program to maximize federal participation make the Indiana P4P program unique. We recommend that Colorado endeavor to maximize the federal participation in its P4P program to enable it to increase its financial commitment to P4P. We also recommend that the Department investigate all opportunities for increasing its financial investment in P4P as higher P4P per diems may increase provider participation.

**Kansas**

Kansas uses two separate per diem add-ons in its P4P program. The first is the Quality and Efficiency Incentive Factor (incentive factor) and is tied to quality of care performance measures. The second add-on is the PEAK 2.0 incentive factor (PEAK incentive) and is related to person-centered care. Each add-on is determine by criteria established in the Medicaid state plan and providers can earn as much as $9.50 per day.

Three outcomes measures are used to determine the incentive factor. The first is the case mix adjusted nurse staffing ratio. This measure calculates the average hours or direct care staff per resident day and then uses home and state case mix information to adjust the average to match the statewide average case mix. This enables the state to compare staffing ratios between facilities without a skewed influence of varying acuity levels. The state recognizes the top 25% of providers with a $2.25 per diem add-on. Providers that do not make the top 25% for this measure can receive a smaller add-on of $0.20 for showing 10% or more improvement in this measure over the last year. The state uses this measure in recognition of studies that have

shown a high correlation between staffing levels and quality of care as indicated by survey results.

The second incentive outcomes measure is based on staff turnover. The staff turnover rate is determined for each home's direct care staff. Facilities with a turnover rate at or below the 75th percentile receive an add-on of $2.25. The facilities that miss this best 25% but that show improvement of 10% or more can qualify for a lower add-on of $0.20. The state includes this measure in the incentive factor due to research that has shown that staff turnover is also highly correlated with quality of care as measured by survey performance.

The third outcome measure that is used for the incentive factor is Medicaid occupancy. Facilities with a Medicaid occupancy of 60% or more earn a $1.00 per diem add-on. The state uses this measure to recognize those providers that carry a heavier than average share of the Medicaid caseload (the statewide average Medicaid occupancy is approximately 55%).

The total per diem add-on that is available to providers for the incentive factor is $5.50.

The second P4P add-on that Kansas uses is the PEAK incentive, which measures and rewards each provider's pursuit of person-centered care. This add-on is determined by an evaluation of each provider's achievements in adopting person-centered care as denoted by six different levels. The first three levels of this initiative involve a quality improvement process where the provider completes a self-assessment to measure how much it has adopted person-centered care and the formulates a plan for improving. The upper three level of the program recognize homes that have met the requirements to be recognized as a person-centered care home, as well as those that have sustained this designation and those that have gone on to mentor other providers. The per diem add-ons for the PEAK incentive increase across the levels ranging from $0.50 for participating in Level 0 Foundation to $4.00 for mentors. The table below summarizes the different PEAK levels and corresponding add-ons.

| **PEAK 2.0 Incentive** | | | |
|---|---|---|---|
| **Level** | **Title** | **Criteria** | **Add-on** |
| 0 | Foundation | Home commits to completing person-centered care education program. | $ 0.50 |
| 1 | Pursuit of Culture Change | Home creates an action plan to address shortcomings related to person-centered care. | $ 0.50 |
| 2 | Culture Change Achievement | Home completes at least 75% of the core person-centered care competnecies it included in its Level 1 action plan. | $ 1.00 |
| 3 | Person-Centered Care Home | Home demonstrates it has met the minimum competencies to be recognized as a person-centered care home. | $ 2.00 |
| 4 | Sustained Person-Centered Care | Home earns person-centered care home designation for at least two consecutive years. | $ 3.00 |
| 5 | Person-Centered Care Mentor Home | Home has earned sustained person-centered care home designation and provided mentor activities to peers. | $ 4.00 |

When combined the two Kansas incentive factors provide recognition for achievements in quality of care and quality of life. This is similar to Colorado's P4P program although much less in depth. Some aspects of the Kansas P4P program that are unique include its payment to providers for committing to participate in person-centered care initiatives and its recognition of providers that show improvement but miss the incentive factors highest criteria.

Kansas has made a significant policy commitment to improving quality of care and quality of life through value based payments with its incentive factors. By reviewing average rate calculations and expenditure estimates we were able to estimate the financial impact of this commitment. The day-weighted average Medicaid nursing facility rate in Kansas for fiscal year 2016 is $158.33. The day weighted average incentive factor is $1.33 and the day-weighted average PEAK incentive is $0.65. So the total of the day-weighted average incentives is $1.98 and represents approximately 1.25% of the day-weighted average Medicaid rate. The estimated fiscal year 2016 nursing facility program expenditures are $390.0 million with a state share contribution of $158.6 million. Applying the percentage of the average rate that is tied to the two incentive factors this would mean that Kansas spent approximately $4.9 million with a state share of approximately $2.0 on value based payments to nursing facilities.[1]

### Recommendation 8

We recommend that Colorado consider ways to recognize providers that are just beginning to take steps towards improving quality of care and quality of life. This might be accomplished by further stratifying the P4P levels in the Colorado program. The Department could also accomplish this by including criteria in more measures that awards points to providers for making significant progress on a measure.

**Minnesota**

Minnesota has a long history of value based payment initiatives. In 2005 they started developing their Quality Add-on program. In 2006 they implemented a Performance-based Incentive Payment Program. In 2013 the state instituted its Quality Improvement Incentive Payment Program (QIIP). Most recently, the state implemented cost based rate setting with limits based on quality effective January 1, 2016.

Related to these initiatives is the Minnesota Nursing Home Report Card that includes data on several performance measures. This report card includes nursing home-specific data on seven measures including resident satisfaction/quality of life, quality indicators/clinical quality, hours of direct care, staff retention, use of temporary nursing staff, proportion of beds in single bedrooms, and state inspection results. The Minnesota Nursing Home Report Card is available online at nhreportcard.dhs.mn.gov. Users can retrieve data based on the location they are concerned with and can designate which measures they want included in the report. This allows the user to customize the report and focus on the information that is most important to them.

The Quality Add-on (QAO) program utilized data from the Report Card. This add-on to the reimbursement rate was determined by each home's quality score determined by Report Card measures. The score was based 50% on quality indicators, 40% on quality of life, and 10% on inspection findings. The QAO was first funded for fiscal year 2007 and provided for an add-on

[1] http://budget.ks.gov/publications/FY2017/FY2017_GBR_Vol1--01-13-2016.pdf

to the reimbursement rate of up to 2.4%. This add-on was then included in the base rate for future years. Funding for the QAO program was much less in fiscal year 2008 when the add-on was restricted to up to 0.3% of the rate, but again this add-on became a part of the base rate going forward. Funding was allocated for the QAO between fiscal year 2009 and fiscal year 2013. It was funded for fiscal year 2014 when it was limited to 3.2% of the reimbursement rate. The QAO was dropped when Minnesota restructured its reimbursement program after fiscal year 2014 but the quality score was continued and is now used to establish limits in the state's new cost based reimbursement system.

Beginning January 1, 2016, Minnesota implemented a system where it uses the home's quality score to set the home's total care-related limit. The total care-related limit for each home is determined by a formula that incorporates that home's quality score. The formula uses the seven-county Metro (Minneapolis/St. Paul) area care-related median as its base. This base is then multiplied by a factor that is determined in part by the home's quality score. Thus the facility-specific limit reflects the quality score in that the higher the quality score the higher the limit will be. A home with a quality score of 10 would have a limit equal to 95% of the seven-county metro median. In contrast a home with a quality score of 90 would have a limit of 140% of the seven-county metro area median. There are provisions that protect providers from significant rate decreases due to this new system, primarily the new system cannot produce rates that are lower than those that were in effect on December 31, 2015.

Determining the fiscal impact of the quality score adjusted limit is nearly impossible. The state previously used a price-based payment system with annual inflation so there are no previous care-related limits to compare the new limits to. In addition the state also increased funding for nursing home rates by a considerable amount resulting in an average rate increase of nearly 22%. This increase was tied to a number of other initiatives that were incorporated into the reimbursement system redesign.

Minnesota also has two incentive based payment programs. The Performance-based Incentive Payment Program was initiated in 2006. It rewards quality improvement through a competitive program offering rate increases of up to 5% for up to three years. Providers must initiate the projects and assume 20% risk for outcomes, meaning they are only guaranteed 80% of the state's approved funding. Since 2006 the program has provided $6.7 million in state funding annually. Of the 370 facilities that participate in the Minnesota Medical Assistance program, 246 have participated in PIPP, 58 have applied but not been selected, and 67 have never applied.

The second incentive based payment program is the Quality Improvement Incentive Payment Program. This program started in 2013 with the first award effective October 1, 2015. Facilities select topics in any quality indicator or quality of life domain. They set goals to improve by one standard deviation over the course of one year and must attain at least the 25$^{th}$ percentile. The state contributes $2.8 million of general funds to this program with the maximum award set at $3.50 per resident day. The state's funding level only allows for a per diem of about $1.75 but most facilities fall short of their goal and therefore receive a prorated per diem. This has enabled the state to stay within its allocated funding limit but there is no provision to prorate the add-ons should the awards exceed to the total funding. All but three of the state's Medicaid nursing facilities are participating in this program.

### Recommendation 9

We recommend that Colorado investigate the use of a Quality Improvement Incentive Payment Program similar to Minnesota. The participation response that Minnesota has observed relative to the funding the state has committed indicate that the program is an effective way to encourage improvement. Such a program could also complement the current Colorado P4P program as the P4P program could be used to identify topics for facilities to focus on.

### Recommendation 10

We recommend that Colorado develop an online report similar to the Minnesota Report Card as another means for sharing the P4P evaluation information. This would allow users to customize reports to focus on the facilities and measures that are most important to them. It would also make the results of the P4P program more accessible, and it would provide a Colorado specific online comparison tool.

# *CMS Pay for Performance Initiatives*

The Centers for Medicare and Medicaid Services (CMS) has included VBP and P4P programs in its strategies for improving health care services and lowering health care costs. The agency has developed and incorporated such programs into the direct provider reimbursement systems it manages through Medicare. The agency has also encouraged states to do the same with Medicaid payment programs. CMS has promoted these strategies through the Triple Aim initiative and the Innovation Center. While these efforts do not include any programs specifically directing states to pursue P4P reimbursement for nursing facilities, they do provide a couple of examples of such innovative programs. They also demonstrate the VBP principles that CMS expects to become more standard in the immediate future.

**The CMS Triple AIM and Value Based Payments**

In January 2015, CMS announced that by the end of 2016, 30 percent of fee-for-service Medicare payments would become value-based payments, through alternative models like Accountable Care Organizations (ACOs) and bundling. Additionally, CMS plans to have 55 percent of fee-for-service Medicare payments shift to quality-based payments by the end of 2016 through P4P programs. This announcement signaled a dramatic new emphasis on value based payments as opposed to volume based payments.[2]

Value based payments including P4P models support the CMS triple aim initiative. The triple aim initiative was formally introduced in 2008 and has since become a national strategy for tackling health care issues. The triple aim emphasizes three outcomes; better care for individuals, better health for populations, and lower costs. VBP programs complement this initiative since they help shift provider payments towards quality and away from quantity. CMS has implemented four VBP programs including; the Hospital Value Based Purchasing Program, the Hospital Readmission Reduction Program, the Value Modifier Program, and the Hospital Acquired Conditions Program.[3]

Although CMS has focused on hospital and physician care with its initial VBP programs, it has plans to implement such programs in other areas over the next few years. Included in these plans is the Skilled Nursing Facility Value Based Payment Program scheduled for implementation in 2018.

The SNFVBP Program will reward skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare. The program will promote better clinical outcomes for skilled nursing home patients and make their care experience better during skilled nursing home stays. CMS will pay participating skilled nursing facilities for their services based on the quality of care, not just quantity of the services they provide in a given performance period. [4]

[2] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html
[3] http://www.healthleadersmedia.com/health-plans/7-years-triple-aim-transcends-jargon#
[4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

The Protecting Access to Medicare Act (PAMA) of 2014 directed the Secretary of Health and Human Services (HHS) to create the SNFVBP Program and gives details about the measures it will address and how nursing home performance will be reimbursed. The initial measure focuses on hospital readmissions for all causes and all conditions. The program will shift to a resource use measure as soon as possible to reflect an all-condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities. Reimbursement to providers will be calculated by a factor applied to the traditional Medicare reimbursement rate. The factor will be established for each provider based on their performance measures. Applying this factor will make each payment to participating providers value based.[5]

### Recommendation 11

We recommend that Colorado investigate the use of a broader scale value adjustment factor based on its P4P scoring system. Applying such a factor to a larger share of the reimbursement rate would tie a greater percentage of provider payments to quality. Such a program could be phased in over a period of several rate setting cycles in order to allow nursing facilities to adjust and prepare for the change in reimbursement policy. This would also gradually escalate the Department's emphasis on quality.

**CMS Innovation Center**

While the CMS initiative to move the majority of Medicare payments to new reimbursement models clearly illustrates the agency's focus on value based purchasing, its Innovation Center established a commitment to partnering with states to develop innovative payment and service delivery models. The Innovation Center was established through provisions of the Affordable Care Act. It is currently focused on the following activities:

- Testing new payment and service delivery models
- Evaluating results and advancing best practices
- Engaging a broad range of stakeholders to develop additional models for testing[6]

The Innovation Center has one program focused on value based payments to nursing facilities. Through the Nursing Home Value Based Purchasing Demonstration CMS assesses the performance of participating facilities on selected quality measures and then makes incentive payments to those that perform the best or improve the most related to quality. The demonstration is limited to participants in three states; Arizona, New York and Wisconsin.

Each year of the demonstration, CMS assesses each participating nursing home's quality performance based on four domains: staffing, appropriate hospitalizations, minimum data set (MDS) outcomes, and survey deficiencies. CMS award points to each nursing home based on how they perform on the measures within each of the domains. These points are summed to produce an overall quality score. For each State, nursing homes with scores in the top 20

[5] https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf
[6] https://innovation.cms.gov/About/index.html

percent and homes that are in the top 20 percent in terms of improvement in their scores are eligible for a share of that State's savings pool.[7]

The savings pool is determined each year for each State based on Medicare savings that result from reductions in the growth of Medicare expenditures. The pool is the difference in Medicare expenditures for the participating providers compared to non-participating providers. If Medicare expenditures for beneficiaries in participating homes increases by less or decreases by more than expenditures for beneficiaries in non-participating homes the difference is considered the savings pool. CMS anticipated that higher quality of care would result in fewer avoidable hospitalizations, resulting in decreases in Medicare-paid hospitalizations and subsequent skilled nursing home stays.

CMS contracted with L & M Policy Research (L&M) to evaluate the first three years of the demonstration. L&M reported that a savings pool was established for only three of the nine state demonstration years (3 states x 3 years). Furthermore they found that the savings in those three years was only marginal. Anecdotally, they determined through interviews with administrators at participating homes that policy decisions were not influenced by the demonstration program incentives. Rather those decisions were driven by other more immediate concerns[8]

### Recommendation 12

While the Nursing Home Value-Based Purchasing Demonstration presents an interesting theory on how to motivate provider improvement it has not proven successful to this point. Furthermore the nature of the program limits the number of facilities that can participate since a comparison group of providers is required to determine the savings pools. We recommend that Colorado continue to monitor this demonstration but do not recommend pursing such a program now.

[7] https://innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/
[8] https://innovation.cms.gov/Files/reports/NursingHomeVBP_EvalReport.pdf

# *Medicare 5-Star Rating Comparisons*

Overall, 5-Star ratings for nursing homes stated on the Medicare.gov website are derived from health inspections, staffing and quality measures. Steps from the website in calculating the rating verbatim are listed below:

Step 1: Start with the health inspections rating.

Step 2: Add 1 star if the staffing rating is 4 or 5 stars and greater than the health inspections rating. Subtract 1 star if the staffing rating is 1 star.

Step 3: Add 1 star if the quality measures rating is 5 stars; subtract 1 star if the quality measures rating is 1 star.

Step 4: If the health inspections rating is 1 star, then the overall rating cannot be upgraded by more than 1 star based on the staffing and quality measure ratings.

Step 5: If a nursing home is a special focus facility, the maximum overall rating is 3 stars.

The chart below compares each nursing home's Pay for Performance score to their 5-Star rating.

| Provider Name | Pay for Performance Final Score | Overall 5-Star Rating |
|---|---|---|
| Pikes Peak Care & Rehabilitation Center | 48 | Not Available |
| Alpine Living Center | 59 | 1 |
| Applewood Living Center | 42 | 1 |
| Aspen Living Center | Did Not Apply | 1 |
| Belmont Lodge | Did Not Apply | 1 |
| Boulder Manor | 53 | 1 |
| Broomfield Skilled Nursing & Rehab Center | Did Not Apply | 1 |
| Castle Rock Care Center | Did Not Apply | 1 |
| Cedarwood Health Care Center | Did Not Apply | 1 |
| Cherry Creek Nursing Center | 27 | 1 |
| Cheyenne Mountain Care and Rehabilitation Center | 35 | 1 |
| Colonial Columns Nursing Center | Did Not Apply | 1 |
| Colorado State Veterans NH - Fitzsimons | Did Not Apply | 1 |
| Elms Haven Center | Did Not Apply | 1 |
| Fort Collins Health Care Center | 50 | 1 |
| Minnequa Medicenter | Did Not Apply | 1 |
| Monaco Parkway Health and Rehab | 65 | 1 |
| Rehab & Nursing Center of the Rockies | Did Not Apply | 1 |
| Sunset Manor | 62 | 1 |
| Terrace Gardens Health Care Center | 30 | 1 |
| Union Printers Home - LTC | Did Not Apply | 1 |

| | | |
|---|---|---|
| Vista Grande Inn | 65 | 1 |
| Yuma Life Care Center | 53 | 1 |
| Arkansas Valley Regional Medical Center | Did Not Apply | 2 |
| Aspen Center | 21 | 2 |
| Aurora Care Center | Did Not Apply | 2 |
| Bear Creek Care and Rehabilitation Center | 58 | 2 |
| Beth Israel at Shalom Park | Did Not Apply | 2 |
| Bethany Nursing & Rehab Center | Did Not Apply | 2 |
| Canon Lodge Care Center | Did Not Apply | 2 |
| Colorow Care Center | 61 | 2 |
| Columbine Manor Care Center | 32 | 2 |
| Crowley County Nursing Center | Did Not Apply | 2 |
| Crown Crest of Parker | Did Not Apply | 2 |
| Devonshire Acres | 51 | 2 |
| Golden Peaks Care and Rehabilitation Center | 57 | 2 |
| Grace Healthcare of Glenwood Springs | Did Not Apply | 2 |
| Hildebrand Care Center | 44 | 2 |
| Julia Temple Healthcare Center | 84 | 2 |
| Juniper Village - The Spearly Center | 67 | 2 |
| Life Care Center of Colorado Springs | 0 | 2 |
| Lincoln Community Hospital and Nursing Home | Did Not Apply | 2 |
| Mission San Miguel Nursing & Rehabilitation Center | 27 | 2 |
| Palisade Living Center | 64 | 2 |
| Parkmoor Village | Did Not Apply | 2 |
| Peaks Care Center | 37 | 2 |
| Pearl Street Health & Rehab Center | 71 | 2 |
| Pioneer Health Care Center | Did Not Apply | 2 |
| Pueblo Care and Rehabilitation Center | 22 | 2 |
| Sierra Vista Health Care Center | Did Not Apply | 2 |
| Spring Creek Health Care Center | 50 | 2 |
| Springs Village Care Center | 47 | 2 |
| Sterling Living Center | 50 | 2 |
| Sundance Skilled Nursing & Rehabilitation | Did Not Apply | 2 |
| Trinidad Inn Nursing Home | 50 | 2 |
| Valley Manor Care Center | 76 | 2 |
| Villas at Sunny Acres | Did Not Apply | 2 |
| Walbridge Memorial Convalescent Wing | 35 | 2 |
| Windsor Health Care Center | 61 | 2 |
| Woodridge Terrace Nursing & Rehabilitation | 10 | 2 |
| Autumn Heights Health Care Center | 38 | 3 |
| Avamere Transitional Care and Rehab - Brighton | Did Not Apply | 3 |
| Berthoud Living Center | 80 | 3 |

| | | |
|---|---|---|
| Centura Health - Medalion Health Center | 0 | 3 |
| Cherrelyn Healthcare Center | 46 | 3 |
| Christopher House | 57 | 3 |
| Colorado State Veterans NH - Rifle | 52 | 3 |
| Courtyard Care Center | Did Not Apply | 3 |
| Englewood Post Acute & Rehab | 0 | 3 |
| Evergreen Nursing Home | Did Not Apply | 3 |
| Four Corners Health Care Center | 82 | 3 |
| Good Samaritan Society - Bonell Community | 63 | 3 |
| Good Samaritan Society - Loveland Village | 21 | 3 |
| Gunnison Valley Health Senior Care | 21 | 3 |
| Hallmark Nursing Center | 41 | 3 |
| Harmony Pointe Nursing Center | 75 | 3 |
| Health Center at Franklin Park | 48 | 3 |
| Highline Rehabilitation and Care Community | 63 | 3 |
| Kenton Manor | 63 | 3 |
| Lakewood Villa | Did Not Apply | 3 |
| LaVilla Grande Care | 61 | 3 |
| Life Care Center of Pueblo | Did Not Apply | 3 |
| ManorCare Health Services-Denver | Did Not Apply | 3 |
| Mesa Manor Care and Rehabilitation Center | 61 | 3 |
| Mountain Vista Nursing Home | 27 | 3 |
| North Star Community | 71 | 3 |
| Orchard Park Health Care Center | Did Not Apply | 3 |
| Rio Grande Inn | 23 | 3 |
| Riverwalk Post Acute & Rehabilitation Center | 30 | 3 |
| Rock Canyon Respiratory and Rehabilitation Center | 39 | 3 |
| San Juan Living Center | 80 | 3 |
| San Luis Care Center | 36 | 3 |
| Sandrock Ridge | 52 | 3 |
| Sedgwick County Hospital and Nursing Home | Did Not Apply | 3 |
| Skyline Ridge Nursing & Rehabilitation CTR | 48 | 3 |
| The Pavilion at Villa Pueblo | 42 | 3 |
| Valley Inn | 58 | 3 |
| Valley View Health Care Center | 69 | 3 |
| Willow Tree Care Center | 33 | 3 |
| Allison Care Center | 56 | 4 |
| Avamere Transitional Care and Rehab - Malley | 56 | 4 |
| Bent County Healthcare Center | 26 | 4 |
| Berkley Manor Care Center | 32 | 4 |
| Briarwood Health Care Center | 36 | 4 |
| Bruce McCandless Colo State Veterans NH | 53 | 4 |

| | | |
|---|---|---|
| Cambridge Care Center | 62 | 4 |
| Casey's Pond Senior Living | Did Not Apply | 4 |
| Cedars Health Care Center | Did Not Apply | 4 |
| Centennial Health Care Center | 82 | 4 |
| Clear Creek Care Center | 62 | 4 |
| Colorado State Veterans NH - Homelake | 66 | 4 |
| Cottonwood Care Center | 50 | 4 |
| Cripple Creek Rehab and Wellness | Did Not Apply | 4 |
| Eben Ezer Lutheran Care Center | 64 | 4 |
| FairAcres Manor | 63 | 4 |
| Forest Street Compassionate Care Center | 0 | 4 |
| Fowler Health Care | Did Not Apply | 4 |
| Garden Terrace Alzheimer's Center | 0 | 4 |
| Good Samaritan Society - Fort Collins Village | Did Not Apply | 4 |
| Grace Manor Care Center | 43 | 4 |
| Heritage Park Care Center | Did Not Apply | 4 |
| Hillcrest Care Center & The Towers | 16 | 4 |
| Horizons Health Care Center | 48 | 4 |
| Jewell Care Center of Denver | 80 | 4 |
| Lamar Estates, LLC | Did Not Apply | 4 |
| Larchwood Inns | 63 | 4 |
| Laurel Manor Care Center | Did Not Apply | 4 |
| Life Care Center of Evergreen | Did Not Apply | 4 |
| Life Care Center of Littleton | Did Not Apply | 4 |
| Life Care Center of Longmont | 28 | 4 |
| Life Care Center of Westminster | Did Not Apply | 4 |
| ManorCare Health Services-Boulder | Did Not Apply | 4 |
| Mantey Heights Rehabilitation & Care CTR | 66 | 4 |
| Mapleton Care Center | Did Not Apply | 4 |
| Mesa Vista of Boulder | 57 | 4 |
| Monte Vista Estates, LLC | 61 | 4 |
| Park Forest Care Center | 21 | 4 |
| Parkview Care Center | 62 | 4 |
| Rowan Community Inc | 61 | 4 |
| Sunny Vista Living Center | 20 | 4 |
| The Gardens Skilled Nursing & Rehabilitation | Did Not Apply | 4 |
| Uptown Health Care Center | 69 | 4 |
| Walsh Healthcare Center | 66 | 4 |
| Amberwood Court Care Center | 75 | 5 |
| Arvada Care & Rehab Center | 30 | 5 |
| Brookshire House | 67 | 5 |
| Brookside Inn | 89 | 5 |

| | | |
|---|---|---|
| Centura Health - Namaste Alzheimer Center | 46 | 5 |
| Cheyenne Manor | Did Not Apply | 5 |
| Colorado State Veterans NH - Walsenburg | 69 | 5 |
| Columbine West Health & Rehab Facility | 53 | 5 |
| Cottonwood Inn Rehabilitation & Extended Care Center | 23 | 5 |
| Denver North Care Center | 84 | 5 |
| E. Dene Moore Care Center | 86 | 5 |
| Eagle Ridge at Grand Valley | 81 | 5 |
| Exempla Healthcare/Colorado Lutheran Home | 63 | 5 |
| Frasier Meadows Manor Health Care Center | Did Not Apply | 5 |
| Good Samaritan Society - Simla | Did Not Apply | 5 |
| Holly Heights Nursing Home | 92 | 5 |
| Holly Nursing Care Center | 66 | 5 |
| LeMay Health & Rehab Center | 40 | 5 |
| Life Care Center of Greeley | Did Not Apply | 5 |
| Little Sisters of the Poor-Mullen Home | Did Not Apply | 5 |
| Littleton Care & Rehab Center | Did Not Apply | 5 |
| Mount St. Francis Nursing Center | 74 | 5 |
| North Shore Health and Rehab | 43 | 5 |
| Paonia Care & Rehabilitation Center | 43 | 5 |
| Pine Ridge Extended Care Center | 70 | 5 |
| Prospect Park Living Center | Did Not Apply | 5 |
| Regent Park Nursing & Rehabilitation | 7 | 5 |
| Rehabilitation Center at Sandalwood | 74 | 5 |
| Sharmar Village Care Center | 0 | 5 |
| Sierra Healthcare Community | 77 | 5 |
| Southeast Colorado Hospital and LTC CTR | Did Not Apply | 5 |
| St. Paul Health Center | 62 | 5 |
| Summit Rehabilitation and Care Center | 75 | 5 |
| The Green House Homes at Mirasol | 65 | 5 |
| The Progressive Care Center | Did Not Apply | 5 |
| The Suites at Clermont Park | 47 | 5 |
| The Suites at Someren Glen | 19 | 5 |
| University Park Care Center | Did Not Apply | 5 |
| Valley View Villa | 26 | 5 |
| Villa Manor Care Center | 0 | 5 |
| Village Care & Rehab Center | Did Not Apply | 5 |
| Washington County Nursing Home | Did Not Apply | 5 |
| Western Hills Health Care Center | 20 | 5 |
| Westlake Care Community | 0 | 5 |
| WheatRidge Manor Nursing Home | 74 | 5 |

Of the 59 facilities that did not apply for Pay for Performance in 2016, 11 (19%) had a one star rating, 14 (24%) had a two star rating, 8 (13%) had a three star rating, 14 (24%) had a four star rating and 12 (20%) had a five star rating. Based on these percentages, it appears that perceived poor performance on the home's part is not the cause of forgoing the Pay for Performance application.

It is difficult to draw conclusions when comparing Pay for Performance final scores to overall 5 Star ratings. A score of zero in most cases indicates a prerequisite wasn't meant and does not reflect the actual scoring of the application. In addition, the application is voluntary and it not required that an applicant apply for each measure. More consistent conclusions may be drawn in the future if overall participation increases in the program.

# *List of Recommendations*

While Colorado has a very well developed and complex nursing home P4P system, there are certainly opportunities to evolve and improve that system. There are several sources to look to for inspiration for improvement including candid evaluation of the current system, investigation of other state P4P systems, and review of the innovation and policy guidance CMS has provided. The following list presents an abbreviated listing of the nine recommendations we developed from our review of these sources.

**Recommendation 1**

We recommend that the Department standardize the format, organization, and electronic submission of the application and supporting documentation.

**Recommendation 2**

We recommend that vague language be revised in the application and that some provider outreach and education be conducted so that applicants have an opportunity to be better informed.

**Recommendation 3**

We recommend that Colorado not require applicants to submit a copy of their CDPHE survey for the calendar year under review. In addition, consider adopting Recommendation 5.

**Recommendation 4**

We recommend that the application specify that only documentation dated January 1st through December 31st of the calendar year under review should be submitted with the application, including testimonials, pictures, resident care plans and end of life wishes. Standardized entry cells should also be created for specific measures to create clarity and increase participation.

**Recommendation 5**

We recommend adopting a two stage process to increase the Pay for Performance participation rate to 100%. Phase I would score mathematically based measures for all homes based on consistent documentation received directly from the Department or its vendors. Phase II is optional for homes that want to apply for the remaining available points.

**Recommendation 6**

Colorado should consider implementing a prorated quality add-on similar to the Indiana model.

**Recommendation 7**

We recommend that Colorado endeavor to increase its financial commitment to P4P and to maximize the federal participation in its P4P program.

**Recommendation 8**

We recommend that Colorado consider ways to recognize providers that are just beginning to take steps towards improving quality of care and quality of life.

**Recommendation 9**

We recommend that Colorado investigate the use of a Quality Improvement Incentive Payment Program similar to Minnesota.

### Recommendation 10

We recommend that Colorado develop an online report similar to the Minnesota Report Card as another means for sharing the P4P evaluation information.

### Recommendation 11

We recommend that Colorado investigate the use of a broader scale value adjustment factor, applying the score based on its P4P scoring system to more than just the incentive add-on.

### Recommendation 12

We recommend that Colorado continue to monitor the CMS Nursing Home Value-Based Demonstration but do not recommend pursuing such a program now.