Colorado Department of Health Care Policy and Financing

2017 Nursing Facilities Pay for Performance Application Review

Recommendations Report

June 2017

PCG Health

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1. INTRODUCTION

Public Consulting Group (PCG) was contracted by the Department of Health Care Policy and Financing (the Department) to review, evaluate, and validate nursing home applications for the 2017 (calendar year 2016) Pay for Performance (P4P) program year. This report provides recommendations and considerations moving forward for the P4P Program based on:

- observations and feedback throughout the application review process;
- research into CMS initiatives;
- other states' P4P programs; and
- a literature review of best practices.

2. P4P PROGRAM REVIEW

Over the years, the Department has continued to improve the P4P application and program. The 2017 application process experienced significant changes with the application being completed, submitted, and reviewed via a new customized web portal. The launch of any new web portal will be a challenge. However, the Department, providers, and PCG worked together to successfully submit and review 2017 P4P applications.

Many recommendations from past years' reports were implemented, including standardizing the format, organization, and electronic submission of the application and supporting documentation, and specifying for each measure in the application that only documentation from January 1st through December 31st of the calendar year under review should be submitted. Although implemented, further clarity and improvement can still be made around these recommendations in an effort to provide clear direction and ease to the application process for providers. In turn, with the end goal of improving quality of care at facilities statewide, these efforts will help to reduce the discrepancy between applicant self-scores and reviewer scores, minimizing provider appeals. This section outlines opportunities for further application, process, and program refinement.

To complete the analysis and recommendations in the following sections (2.1–2.3) of this P4P Program Review, section, PCG has:

- noted observations throughout the review process,
- collected feedback from the Department and providers on the application and review process, and
- reviewed previous years' reports and data to identify recommendations that are still relevant and have not yet been implemented.

2.1 P4P Application

Minimum Requirements Specificity and Standards

The 2017 application was revised by the P4P Committee to ensure clarity for providers and reviewers. However, further revisions can and should be made to the minimum requirements language within each measure. The review team noted minimum requirements are sometimes vague or inconsistent in terms of what providers were actually required to submit as supporting documentation. In turn, the review team understood where there can potentially be a disconnect for the providers as they submit their applications. Reviewing applications objectively, PCG made determinations based on the exact language in the minimum requirements. Major themes in the minimum requirements that should be reviewed and updated accordingly for increased application clarity and specificity are outlined in the table below, with an example of a related minimum requirement.

Theme	Example	
	Measure	Minimum Requirements (issue in bold/italics)
Vague language within a requirement, such as "may include" vs. "must include"	Staff Engagement	- A written narrative of a program that includes staff mentoring and/or buddy system for new staff. - ***Documentation may also include*** an outline or policy for buddy system and mentoring program(s).
Consistency in requirements for different measures	Enhanced Dining	Supporting documentation can be ***resident signed testimonials***, resident council minutes, minutes from another advisory group and photographs of changes in the dining atmosphere.
Clear direction on what documentation is required and how best to incorporate/submit documentation	Connection and Meaning	***Based upon the community assessment completed under person-directed care***, describe what opportunities you have identified to provide connection and meaning to your residents. In addition, describe how you incorporated those opportunities to foster the connection and meaning into the resident's daily lives.

For the Staff Engagement measure, it was difficult to discern whether an outline or policy for a buddy system and mentoring program(s) had to be included with the supporting documentation for this measure, or whether a written narrative was sufficient. From the reviewer's perspective, it was clear many applicants considered the submission of an outline or policy optional.

Numerous measures require testimonials to be submitted as part of the supporting documentation. However, Enhanced Dining is the only measure with a requirement that states testimonials must be signed. Consistency throughout the application, such as making all testimonials require a signature or making no testimonials require a signature, should be adopted and updated.

The Connection and Meaning measure includes a minimum requirement that is related to the community assessment, which is required to be completed and submitted under a different measure. In the application, there should be clear direction on how to mention or reference the community assessment in the connection and meaning description. In addition, it should be noted whether this community assessment must be included as part of the application (i.e. if a home does not submit a community assessment under Person-Directed Care, no points can be awarded for Connection and Meaning).

The Department and review team should define and approve review standards to help manage provider expectations and help providers understand the review process. There were some instances this review year where a review standard or requirement was unclear or changed during the calendar year. For example, testimonials being dated in 2017 instead of 2016 and the date range of the submitted re-hospitalization data. Better defining the minimum requirements and developing clear review standards will only help to provide clarity to all stakeholders.

Recommendation 1: *Continue to review each measure and minimum requirement in the application. Ensure the P4P Committee, providers, the Department, and review team are clear on all minimum requirements and documentation submission requirements. Provide examples, as applicable, of what should be submitted so all parties are on the same page.*

Recommendation 2: *Develop and approve clear review standards based on the application minimum requirements between the Department and review team. Identify any questions early in the submission and review process and communicate decision points and standards to all parties.*

Supporting Documentation & Administrative Burden

The 2016 P4P Recommendations Report, feedback collected during the on-site reviews with nursing facility administrators and staff, and working through the 2017 review process, all make it clear that an administrative

burden of applying and submitting an application with documentation clearly exists. While it is reasonable and necessary that nursing home applicants submit documentation to ensure all requirements are being tracked and met throughout the year, there are areas where the administrative burden can be reduced. For example, in 2016 the Colorado Department of Public Health and Environment (CDPHE) survey was required to be submitted with the P4P application. This requirement was removed for this past review year and the Department sent PCG a spreadsheet with stated deficiencies and PCG confirmed that all 2017 applicants met the CDPHE prerequisite requirement.

Additional opportunities to lessen the administrative burden for the providers should be identified by the Department, P4P Committee, and PCG. Two approaches to identifying these opportunities are:

1. Reviewing and reassessing the minimum requirements for the more qualitative measures and requirements
2. Reviewing and determining the availability and sources of data for the more quantitative measures and requirements

These two approaches are conducted each application year as the P4P program evolves, however, a more focused effort on identifying these opportunities will ease the application submission process and review process. Examples include:

- Reviewing and reassessing the minimum requirements for the Physical Environment measure. There are a lot of requirements baked into this measure, including, "Include one photo of each item listed in your narrative." Forty-eight facilities lost points in their 2017 application due to missing part of a minimum requirement in this measure.
- Reviewing and determining the availability of data, including the nationally reported quality measure scores and re-hospitalization data. Multiple facilities lost points for not submitting CASPER reports or Trend Tracker/Advancing Excellence re-hospitalization data.

In regard to quantitative measures and documentation, such as the nationally reported quality measures and associated CASPER reports, applicants must identify values from reports/data, calculate scores, enter the scores into the application, and submit reports as supporting documentation. Although there are calculation tools and appendices embedded within the application, this process caused inefficiencies in the application and review process as applicants sometimes entered inaccurate scores as part of their application self-score. As reviewers must review the CASPER reports and scores regardless to ensure accuracy, requiring applicants to enter their own self-scores for these measures is a duplicative effort. If the necessary data and reports is accessible by the Department and/or review team, eliminating submission requirements while keeping these quantitative measures would not impact the integrity of the application standards.

Another observation during the appeals process was nursing homes stating that they had documentation to support a measure or requirement, however it was never uploaded to the system. No new documentation was allowed to be submitted and reviewed during the appeals process, however some facilities did have documentation on file that could have awarded them additional points. Developing a two-phase submission process (prior to the appeals process) in which homes have two opportunities to submit documentation may help to increase participation and increase final scores.

In addition, in last year's Recommendations Report, a two stage process was recommended. Phase I would score mathematically based measures for all homes based on consistent documentation received directly from the Department or its vendors. Phase II would be optional for homes that wanted to apply for the remaining available points. Potentially combining these multi-phase approaches could help lessen the administrative burden for applicants and provide multiple opportunities to ensure all supporting documentation was in fact included in the submission. In turn, this would ultimately lead to higher provider participation and final scores. Further discussion with the Department and P4P Committee must occur to analyze the additional administrative effort to ensure a successful multi-phase application process.

Recommendation 3: *Review and revise submission requirements for qualitative and quantitative measures. Determine any minimum requirements requesting substantial information. Identify any reports or data that can be*

obtained by the Department (i.e. CASPER reports) and reviewed by the review team. This would simplify the application process for the nursing homes and may encourage participation in the program. Furthermore, this eases the administrative load on administrators and managers who can then focus on ensuring they meet other application measures.

Recommendation 4: *Consider a multi-phase application submission process that would help reduce the administrative burden for providers and provide multiple opportunities to submit supporting documentation as part of the application.*

2.2 Online System Application

This was the first year that the entire P4P application was completed, submitted, and reviewed via an online web portal. Overall, the online system application was a success and P4P applications were successfully submitted and reviewed. However, throughout the review process providers, the Department, and the review team identified potential system enhancements, including:

- Send an automated confirmation to each provider once the application is submitted
- Display a clearer notification/confirmation when documentation is successfully or unsuccessfully uploaded to the system
- Better link the uploaded documentation to each measure or minimum requirement, in an effort to ensure all documentation has been uploaded by the provider
    - Include files on the actual measure page
    - Add a checklist, attestation, and/or flag for supporting documentation requirements
    - Reminders built into the portal requesting the applicant to upload all documentation for each requirement
- Continue to recognize this is a system application and not an Excel application. Customize the application for a more "system-like" experience, including:
    - Review the necessity of selecting "Yes", "No", and "N/A" for every minimum requirement, especially in cases where the requirement is more for informational purposes and does not require sign off or supporting documentation
    - Ensure clarity between measure description and minimum requirements and all requirements are clearly displayed on each measure page
    - Ensure the language refers to the system pages and system tools/appendices and not the Excel spreadsheet
- Allow multiple users to access the application per one facility
- Increase the amount of time (from 15 minutes) before a user is logged out of the system for inactivity on a page

Many of these enhancements would help with ease of submission for the nursing homes and the review process for the review team. Overall, user experience, creating a clear standardized submission process, and lessening the administrative burden are major goals of the system application. The Department and PCG should work together to review and prioritize enhancements that will have the most impact in terms of improving the submission and review process for the 2018 application year.

Recommendation 5: *Review and prioritize system enhancements to help improve the application submission and review processes.*

2.3 Program Development and Participation

This year's application provided more clarity in its description of minimum requirements and specifying that supporting documentation must be from the reporting calendar year, January 1, 2016 through December 31, 2016. However, there were a number instances in which an applicant still lost points due to incomplete documentation or providing documentation that fell outside of calendar year 2016. During on-site reviews, PCG inquired if there was

any confusion or vagueness in the application requirements and overall nursing home staff generally stated they understood the application and requirements.

There is still value in continuing to emphasize the requirements and conduct outreach and education regarding the application and its requirements prior to and during the application process. Furthermore, with the new web portal application, there were instances where applicants selected "Yes" to meeting a minimum requirement but no supporting documentation was uploaded, and in turn the home lost points for this measure. While the applicant may have unintentionally selected "Yes", it is also reasonable that an applicant forgot to upload or overlooked the documentation.

To help applicants submit the most complete application, a checklist or reminders/flags could be developed and used as a stand-alone education document and/or be embedded in the application. The checklist can serve as a friendly reminder for nursing home applicants and include items such as:

- Review and ensure that all your supporting documentation is for the timeframe of January 1 to December 31 of the calendar year
- Check that you have uploaded supporting documentation for any minimum requirement in which you indicated "Yes" on each page
- Review the "Participant Completion Summary" page and make sure the self-score for each measure aligns with your selections and uploaded documentation, ensuring no measure was unintentionally left incomplete

This checklist could also be included on the Participant Completion Summary page in the system, requiring the providers attest that all documentation was submitted for each requirement. This extra step in the submission process could result in improved self-scores, and in turn improved reviewer scores for nursing facilities.

Using a version of this checklist as a provider training and education tool will also help set provider expectations throughout the year and during the application submission process. Additionally, best practices and submission guidelines should be communicated to providers on a more consistent basis in an effort to maximize the standardization of the online application submissions. After completing the first review year using the web portal, the following recommendations were identified by the review team:

- Submit only the required documentation needed for each measure and organize/upload documentation in a concise manner. This includes combining related items, such as all photos for the Physical Environment measure, or all care plans for the Care Planning measure, and where applicable combining items by each minimum requirement within a measure. This will help the reviewer clearly identify which piece of documentation relates to each minimum requirement.
- Clearly label all documentation to match the Measure ID # in the system. It is also recommended that the Excel application use the same numbering format as the system application. This will help ensure standardized numbering and organization throughout the submission process. In addition, a consideration is to also number each minimum requirement within each measure. This could also help providers organize their uploaded documentation and related to the above bullet, help provide clarity for the reviewer in terms of which piece of documentation relates to each minimum requirement.
- If multiple documents for various minimum requirements or even measures are uploaded in one file, clearly label which requirement each piece of documentation is related to, again helping to provide clarity on what requirement every document is supporting.
- Standardize the completion of the appendices in tools in the system versus using the Excel application and uploading scanned printouts of the complete appendices and tools. This will only help to standardize the entire application submission process and limit the number of files that are uploaded.

While the Department communicates with the nursing facilities throughout the year and the on-site reviews provide an opportunity for the review team to talk with providers, soliciting feedback from the broadest range of nursing facilities could be helpful to better understand and confirm changes for the P4P program. A short web survey sent to all nursing facilities throughout Colorado with questions on several subjects could include:

- Level of clarity in language and requirements in the application;

- Ease of applying and submitting an application;
- Helpfulness of training and outreach;
- Ideas and suggestions on existing and potential new measures; and,
- Reasons why facilities do not participate in the program or why they do not apply for particular measures.

As the P4P program has matured over the years, gaining feedback from a wide net of nursing homes can only help continue to advance the program. This could result in increased participation and help to better engage current participants throughout the year.

It is recommended that the nursing facility contact list is continually updated throughout the year. There were a number of bounce-back and undeliverable emails encountered this application year using the contact list initially provided by the Department to the review team. It is understood there is turnover across nursing facilities, however more frequent communication with and outreach to all nursing homes leading up to the application period will help to ensure the web portal has the most up to date information for each facility. Options to ensure contact information is accurate for applicants include issuing mid-year surveys and collecting contact information at trainings throughout the year.

Recommendation 6*: Continue to expand on outreach and training activities to further emphasize application requirements and submission best practices. For example, creating a short checklist of the most important points for a complete application.*

Recommendation 7: *Conduct a short web survey to gather additional insight and experiences from a broad group of nursing facilities. With changes made to the program each year and the maturity of the program, this may be an ideal time to have a more holistic evaluation of the program from the provider-level. The survey can drive participation and engagement of the nursing facilities.*

Recommendation 8: *Ensure the provider contact list is updated throughout the year and has the most up to date information for each participating home as the application process begins allowing maximum time to submit an application.*

3. CMS SNF REVIEW

The Centers for Medicare and Medicaid Service (CMS) continues to work towards initiatives and innovations to improve quality of care at skilled nursing facilities. Last year's P4P Recommendations Report discussed the Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP), a recent CMS initiative. The SNFVBP Program[1] is now planned to be implemented in Fiscal Year 2019. Although this initiative has not been fully implemented, CMS has provided information on the goals and measures of the SNFVBP Program.

The goal of SNFVBP Program is to promote better clinical incomes and better experiences for patients in SNFs. In addition to the traditional payment for services, the program also pays participating SNFs for services based on quality of care measures. Details on the measures, how facilities will be scored, performance standards and periods, how facilities can review their scores, and how scores are reported to the public are included in the Section 215 of the 2014 Protecting Access to Medicare Act (PAMA). However, the annual release of the SNF Prospective Payment System (PPS) rules will outline the requirements of the SNFVBP Program for that performance year. Current measures, as described by CMS, that will be used in the SNFVBP Program are:

> 1) SNF 30-Day All-Cause Readmission Measure (SNFRM): This measure estimates the risk-standardized rate of unexpected readmissions within 30 days for individuals with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals and for any cause or condition.
>
> 2) SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR): This measure estimates the risk-standardized rate of unexpected, potentially preventable readmissions (PPRs) within 30 days for individuals with fee-for-service Medicare who were inpatients as PPS, critical access, or psychiatric hospitals.

CMS provided a Fact Sheet[2] regarding the SNFRM to clarify how this measure is evaluated. A few key facts include:

- Hospital readmission are identified using Medicare claims data; therefore, no additional reporting requirements are expected of the SNFs.
- The measure includes unplanned readmissions as identified using a modified version of the CMS Planned Readmissions Algorithm.
- In comparing facility scores, adjustments will be made to account for patient differences, such as comorbidities.
- Value-based incentives will be determined by comparing all SNFs' performance score on the measure.
- SNFRM will be replaced with the SNFPPR in future rulemaking.

Overall, the SNFVBP Program provides a transparency to both facilities and patients to improve quality of care in SNFs and provides a way to compare performance.

Recommendation 9: *Continue to monitor the progress of the SNFVBP Program, particularly as the measure moves incentivizing potentially preventable readmissions and adjusting scores to account for patient differences across facilities. This measure should be communicated to the P4P Committee and to the nursing homes at provider trainings with the expectation of incorporating this measure as part of the 2019 program year (2018 calendar year) application, to get ahead of Fiscal Year 2019. In addition, consider following the program's application process of not requiring additional reporting from facilities for data that can be obtained and calculated by the Department.*

CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

[1] www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

[2] www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-things-to-know-about-SNFRM.pdf

In 2012, CMS began working on an initiative to improve care for long-stay residents in nursing facilities through a two-phase initiative to reduce avoidable hospitalizations[3]. In the first phase, CMS worked alongside seven Enhanced Care and Coordination (ECCP) organizations that in turn partnered with a group of long-term care facilities (LTC). During this phase, evidence-based clinical and educational interventions were implemented to improve care and lower costs, specifically focusing on residents enrolled in Medicare and Medicaid. In total, the ECCPs partnered with 143 LTC in seven states and reached 16,000 beneficiaries. Over a four-year period, the interventions implemented were evaluated for their effectiveness of improving health outcomes and providing a better care experience. Evaluation reports were submitted in 2016. By the end of the four-year period there was a clearer indication that this initiative effected many measures, including reducing utilization and spending, particularly in some states. However, the initiative's impact on the Minimum Data Set (MDS) based quality measures are limited.

In 2015, CMS announced a second phase to the initiative which began in 2016. This phase allows for organizations who participated in the first phase to test whether a new payment model for LTC facilities, in conjunction with previously implemented interventions, will result in reduced avoidable hospitalizations and also lower Medicare and Medicaid spending for residents[4]. According to CMS, the new payment model funds "high-intensity treatment services for residents who may otherwise be hospitalized upon acute change in condition for any of the six conditions listed". The six conditions listed can be found below and were identified through research that shows the six conditions are linked to 80.3 percent of potentially avoidable hospitalizations for LTC facility residents:

- Pneumonia
- Dehydration
- Congestive Heart Failure
- Urinary Tract Infection
- Skin ulcers, cellulitis
- Chronic obstructive pulmonary disease, asthma.

Additionally, the new payment model will pay LTC practitioners at a similar rate as they would receive for treating beneficiaries in a hospital setting as well as pay practitioners for engaging in multidisciplinary care planning activities. The second phase will also be four years and ECCPs will work with existing partners as well as recruit and screen new providers for participation.

Recommendation 10*: Reward facilities that engage in multidisciplinary care planning activities or preventative care training, particularly to address the common reasons for patient hospital admissions and readmissions. This would improve quality of care for patients while promoting facilities to proactively educate staff on the most concerning health conditions.*

[3] https://innovation.cms.gov/initiatives/rahnfr/

[4] https://innovation.cms.gov/initiatives/rahnfr-phase-two/index.html

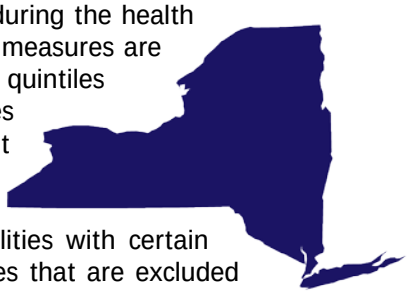
4. OTHER STATES REVIEW

To review best practices for nursing facilities in other states, PCG selected California, New York, and Utah. Each of these states has an established pay for performance program from which Colorado's program could glean information to enhance its program. These programs have been in operation for very different lengths of time. There are also other diverse perspectives from California, New York, and Utah that led PCG to research the best practices of nursing facilities in these states. Geographically, these programs exist in very different parts of the United States and serve vastly different population sizes. Also, each state has a unique methodology for analyzing and rewarding its nursing facilities. To complete its research on other states' programs, PCG relied on several resources including presentations, publicly accessible statistics, and direct communication with the states. Due to the differences in pay for performance programs in California, New York, and Utah, PCG can offer an insightful perspective for the future of Colorado's pay for performance program. However, the maturity and comprehensiveness of Colorado's pay for performance program is evident compared to similar programs in other states.

4.1 Summary of Selected States

The newest of the three state programs, California's Quality Accountability Supplemental Payment Program (QASP) has been in operation since 2014 due to the passage of SB 853.[5] The State also refers to the QASP program as the Quality Accountability Program for Skilled Nursing Facilities. The California Department of Public Health (CDPH) partners with the California Department of Health Care Services (DHCS) to implement QASP. To help DHCS issue incentive payments, CDPH's Center for Health Care Quality assesses and scores each facility's quality of care for its residents. For State Fiscal Year 2017, CDPH and DHCS established new quality measures and point allocations for QASP evaluations. These new measures and point allocations are subject to change in the next State Fiscal Year. Currently, QASP's quality measures are broken down into two categories: Measurement Areas and Quality Measures. In the Measurement Area, the subcategories include Pressure Ulcer Measurement Area, Immunizations Measurement Area, and 30 Day All-Cause Readmission. In the Quality Measure category, Staff Retention, Control of Bowel/Bladder: Long Stay, and Pneumococcal Vaccination: Short Stay are some of the subcategories. Compared to pay for performance programs in other states, QASP is much narrower in focus. However, QASP designates $81 million in Quality payments and $9 million in Improvement payments.[6] In other words, QASP rewards yearly improvement in facilities.

The state of New York has participated in a nursing facility pay for performance program since 2008.[7] Currently, the state's program is referred to as the Nursing Home Quality Initiative (NHQI). NHQI is an annual quality and performance evaluation project that focuses on improving the quality of care for residents in Medicaid-certified nursing facilities across the state of New York. The current NHQI is based on the previous calendar year's performance and is worth 100 points. Nursing homes are awarded points for quality and performance measures in the components of Quality, Compliance, and Efficiency. Specific deficiencies cited during the health inspection survey process are also incorporated into the results. The points for all measures are then summed to create an overall score for each facility. Facilities are ranked into quintiles based on their overall scores. Quintile one represents the top-performing facilities while quintile five represents the lowest-performing. The New York State Department of Health website contains information and results for each year of the NHQI. After downloading from the website, the quintile ranking documents contain the following worksheets: nursing facilities in each of the five quintiles, nursing facilities with certain deficiencies cited during the health inspection survey process, and nursing facilities that are excluded



[5] www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853
[6] www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853
[7] www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf

from the NHQI for various reasons. Nursing homes with one or more J, K, and L health inspection deficiencies are ineligible for ranking, and homes are excluded from the NHQI program if they are:

- Non-Medicaid facilities
- Designated by CMS as a Special Focus Facility at any time during 2015 or 2016, prior to the final calculation of the 2016 NHQI
- Specialty facilities
- Specialty units within a nursing home
- Continuing Care Retirement Communities
- Transitional Care Units

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program is the name of the state's pay for performance program.[8] Based on performance each year, QII pays out a portion of the $5,275,900 taken from the state's general fund per Medicaid certified bed. In total, the QII program has three components-QII(1), QII(2), and QII(3). QII(1) and QII(2) are two independently scored components. QII(1) ensures that quality programs are implemented at the facilities. QII(2) provides incentive for facilities to improve the environment for the residents. QII(2) categories include Patient Life Enhancing Devices, Clinical Software/Hardware, Improved Dining Experience, and Patient Bathing Systems. Scores in either QII(1) or QII(2) are not reliant on the score in the other component. The final component, QII(3)'s score relies on the previous two components. Specifically, to earn all the points for the QII(3) component, a facility must complete all of the QII(1) forms and at least one QII(2) form. QII(3) ensures resident choices are available. To apply for QII consideration, providers must submit cover forms with checklists and supporting documentation to Utah's Department of Health Medicaid Reimbursement Unit. A complete QII application package includes: Application, Spreadsheet, Invoice(s), Proof of Payment, and a PDF for each incentive and email submission. QII is the longest running program out of the reviewed states, in operation since 2004. Utah has not completed much analysis to relate the resident satisfaction level to the QII payments over the years, however the State meets annually with representatives in the Nursing Facilities industry for input on what works and doesn't work for providers. Also, funding is 100% from the state's general funds.

4.2 Other States Analysis

Quality of Care

When reviewing nursing facilities, Quality of Care is an essential domain that California, New York, and Utah all directly address. Each state's pay for performance program utilizes different domains/categories, subcategories, and performance measures to measure Quality of Care. While all three of the states reviewed in this section measure Quality of Care in some way, the performance measures they use are significantly different from one another and from the measures utilized in Colorado's pay for performance program. This section reviews the measures in individual states that align with Colorado's Quality of Care measures.

In California's QASP, the measures for Quality of Care are based on differences between short stay and long stay residents.[9] There are two domains-Measurement Area and Quality Measure. Each of these domains is worth 100 points. Measurement Area is focused on all reported health-related incidents and it includes 9 performance measures. Quality Measure involves comparison of reported health incidents between short stay and long stay residents and includes 11 performance measures. Compared to Colorado's pay for performance program, QASP measures more clinical outcomes to determine Quality of Care. In QASP, both domains feature measurements relevant to Quality of Care. Measurement Area includes the "Incidence of Pressure Ulcers," the "Use of Physical Restraints," and "30 Day All-Cause Readmission." The Quality of Care performance measures in the Quality

[8] http://health.utah.gov/medicaid/stplan/NursingHomes/QI/UHCA_April_2017_Presentation.pdf
[9] www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/QASP_ExistingMeasures.aspx

Measures domain includes "Staff Retention," "Self-Reported Pain" (Short Stay and Long Stay Residents), and the "Influenza Vaccination" (Short Stay Residents).

New York's NHQI program relies on several nationally standardized performance measures to evaluate Quality of Care in the state's nursing facilities.[10] Specifically, the assessment utilized is MDS 3.0, a CMS standardized assessment of nursing home quality. In NHQI, there are three domains, or "Components," for the performance measures. The three Components are Quality (70 points), Compliance (20 points), and Efficiency (10 points). The Quality Component is composed of quality performance measures. The Compliance Component involves nursing facilities' compliance with reporting. Lastly, the Efficiency Component focuses on potentially avoidable hospitalizations. In each of NHQI's Components, there is a performance measure related to Quality of Care.

The Quality Component has 3 non-MDS 3.0 performance measures: "Percent of contract/agency staff used," "Rate of staffing hours per day," and "Percent of employees vaccinated for influenza." This Component also includes 10 MDS 3.0 performance measures related to Quality of Care.

The 10 MDS 3.0 performance measures related to Quality of Care are:

1.) Percent of long stay high risk residents with pressure ulcers
2.) Percent of long stay residents who received the pneumococcal vaccine
3.) Percent of long stay residents who lose too much weight
4.) Percent of long stay residents who received the seasonal influenza vaccine
5.) Percent of long stay residents experiencing one or more falls with major injury
6.) Percent of long stay residents whose need for help with daily activities has increased
7.) Percent of long stay residents who lose control of their bowel or bladder
8.) Percent of long stay residents with dementia who received an antipsychotic medication
9.) Percent of long stay residents who self-report moderate to severe pain
10.) Percent of long stay residents with a urinary tract infection

The Compliance Component features two of three performance measures that are related to Colorado's understanding of Quality of Care. These are the CMS 5-Star Quality Rating for Health Inspections and the Timely submission of Employee Influenza Vaccination Data. Finally, NHQI's Efficiency Component's one performance measure, potentially avoidable hospitalizations, is also related to Quality of Care.

Utah's QII program gathers measurements comparable to Colorado's pay for performance program.[11] However, unlike other state pay for performance programs, QII is separated into three subprograms. These three Quality Incentive Programs are QII(1), QII(2), and QII(3). QII(1) ensures that quality programs are implemented at the facilities. QII(2) provides incentive for facilities to improve the environment for the residents. QII(3) ensures resident choices are available. The performance measures of QII(2) are most related to Quality of Care. These measures include: Patient Lift, Educating Staff, Patient Dignity Devices, Worker Immunizations, Clinical Software, Hardware, and Backup Power.

Quality of Life

Compared to Colorado's pay for performance program, California's QASP and New York's NHQI program are lacking in requesting measurements about Quality of Life. The performance measures of the Quality of Life domain reflect resident choice, sense of community, and staff empowerment. Of the three state programs reviewed in this section, Utah's QII programs most align with Colorado's understanding of Quality of Life. This section will review each state's minor or major evaluation of Quality of Life in nursing facilities.

[10] www.health.ny.gov/health_care/medicaid/redesign/nhqi/2016/methodology.htm
[11] http://health.utah.gov/medicaid/stplan/longtermcarenfqi.htm

California's QASP does not address Quality of Life in either a qualitative or quantitative fashion as does Colorado's pay for performance program.[12] The closest performance measure to Quality of Life that QASP gathers is called "Increased need for help with Activities of Daily Living." Although this measure reflects the health of residents, it also indicates that providers are paying attention to Quality of Life for the residents in their care.

New York's NHQI program essentially has no performance measures about Quality of Life in comparison to Colorado's pay for performance program. As discussed in the previous section, New York is much more focused on Quality of Care measures, particularly in terms of health-related incidents.[13] The one performance measure under the NHQI "Quality Component" that is relatable to Quality of Life is the measure of the "Percent of long stay residents who have depressive symptoms."

In Utah's QII program, all three of its subprograms address Quality of Life in a way similar to Colorado's program.[14] In QII(1), although there are not performance measures related to Quality of Life, it is required that residents and their family members are involved in developing the facility's Quality Improvement Plan. In the second subprogram, QII(2), there are performance measures based on Nurse Call (avoidance of overhead paging), Patient Life, Dining Enhancement, and Bathing. QII(3), the final subprogram of QII is entirely based on the presence of Resident Choice in Awake Time, Meal Time, and Bath Time.

Facility Management

The evaluation of Facility Management in nursing facilities' pay for performance programs is generally lacking in California, New York, and Utah. In general, Facility Management refers to the management of the technical, operational, and occupancy needs of a nursing facility. California's QASP and New York's NHQI each address one aspect of Facility Management in their performance measurements. Utah's QII(2) program addresses two aspects of Facility Management in its subcategories of evaluation.

In California's QASP, both the Measurement Area and Quality Measure address the 30 Day All-Cause Readmission performance measure.[15] This measure is related to Colorado's "Medicaid Occupancy Average" measure under the subcategory of Home Management. Although California does not expound upon how the rate of 30 Day readmissions impact a nursing facility's occupancy, it is a useful measure that provides some insight on Facility Management.

New York's NHQI Compliance Component includes one performance measure somewhat related to Facility Management. The performance measure is "Timely submission of certified and complete nursing home cost reports" and is worth 5 of the 20 points of the Compliance Component.[16] Nursing home cost reports are relevant to facility management in that they reflect the financial management of the facility.

Utah's QII(2) program has 2 performance measures that reflect Facility Management.[17] The first of these measures is Heating, Ventilation, and Air Conditioning (HVAC). To receive points for this measure, a facility must have efficient and continuously operating HVAC. The second performance measure related to Facility Management is Van. An extension of the facility, a van must operate well, provide access for disabled people, and have sufficient space for its occupants.

Program Impact Analysis

[12] www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/QASP_ExistingMeasures.aspx
[13] www.health.ny.gov/health_care/medicaid/redesign/nhqi/2016/methodology.htm
[14] http://health.utah.gov/medicaid/stplan/longtermcarenfqi.htm
[15] www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/QASP_ExistingMeasures.aspx
[16] www.health.ny.gov/health_care/medicaid/redesign/nhqi/2016/methodology.htm
[17] http://health.utah.gov/medicaid/stplan/longtermcarenfqi.htm

States have varying approaches to demonstrating impact and performance of nursing facilities from pay for performance programs. Utilizing charts and graphs, states can depict quality changes in nursing facilities over time and by facility. The analysis of program impact is critical for the improvement of state pay for performance programs. From program impact analysis, a state can evaluate the consequences of its program and create new initiatives to improve nursing facilities in its state.

Per a representative of California's QASP, the state's pay for performance program has resulted in some of the fastest improving nursing facilities in the nation.[18] However, California has not presented the impact of its program publicly. To recognize improvement from the previous year, QASP offers points to facilities that have improved the most. Also, QASP depicts its program's impact with bar graphs of Aggregate versus Quarterly performance overall.

Neither New York's NHQI nor Utah's QII programs provide public analyses of their respective impacts on the quality of nursing facilities. Like QASP, NHQI offers points for improvement from the previous year. In Utah's QII program, the State tracks each QII performance measure application in a database before distributing payments to nursing facilities. In general, Utah has not analyzed the effects of its incentive payments on the quality improvement of participating nursing facilities. Instead, Utah annually seeks input from the nursing facilities' industry for advice on helping providers.

In addition, from literature review research (*Section 5* of this report), Kansas tracks improvements in conjunction with Kansas State University. The University performs an annual review of improvement criteria; if improvement criteria are met, facilities move up a level, and become eligible for more incentives. The levels focus on different domains of person centered care and quality of life areas and facilities must sustain improvements made at lower levels. Additionally, an ongoing, independent study by the Leading Age Center for Applied Research (CFAR) tracks quality of life improvements.

Comparing Facilities

To compare nursing facilities, states utilize rankings and other methodologies. In New York's NHQI and California's QASP, these comparisons directly impact the rewards to facilities. Both state programs give allocated points to each facility based on certain criteria. After point allocation, each program ranks a facility based on the points of all other facilities in the state. To receive a higher award, nursing facilities must outcompete the other facilities in the state. Neither California nor New York publicly offer extensive comparisons of each participating nursing facility.

As mentioned previously, California's QASP focuses on quantitative clinical outcomes rather than the qualitative measures that Colorado's pay for performance program reviews.[19] Such quantitative measures could prove beneficial for Colorado to incorporate in its review of nursing facilities. When comparing facilities, QASP focuses on quality measures from the national and state level. In contrast with Colorado's pay for performance program, QASP's focus on quantitative clinical outcomes that provide a more objective analysis of the quality of nursing facilities.

New York's NHQI utilizes quintile rankings per year to compare nursing facilities that participate in the program.[20] NHQI does not specify the populations of each facility, but excludes Non–Medicaid facilities, any facility designated by CMS as a Special Focus Facility at any time during 2016 or 2017 prior to the final calculation of the 2017 NHQI, Specialty facilities, Specialty units within a nursing home (i.e. AIDS, pediatric specialty, traumatic brain injury, ventilator dependent, behavioral intervention), Continuing Care Retirement Communities, and Transitional Care Units. Utah's QII program releases nursing home ratings following its review but does not explicitly compare facilities.

[18] www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/QASP_ExistingMeasures.aspx

[19] www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/QASP_ExistingMeasures.aspx

[20] www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/methodology.htm

Addressing Crises

Tackling immediate jeopardy situations and substandard deficiencies (J, K, and L) on surveys are issues that states with pay for performance programs face. Pay for performance scores that reflect urgent, troubling situations in nursing facilities present states with opportunities for immediate action. In New York's NHQI and California's QASP, nursing facilities with severe deficiencies are ineligible for ranking and thus for an award from the program. To qualify for payment under Utah's QII(1) program, a facility must not have received any immediate jeopardy violations at the "most recent re-certification survey and during the incentive period." If not eligible for QII(1), a facility cannot apply for QII(3). However, a facility can apply for any QII(2) applications regardless of violations and QII(1) eligibility.

In California, nursing facilities that receive serious care citations are excluded from QASP awards the year that the deficiencies occur. Similarly, nursing facilities in New York that receive one or more serious health inspection deficiencies are ineligible to be ranked into NHQI quintiles.[21] New York refers to an immediate jeopardy situation as one in which a deficiency resulted in noncompliance and immediate action was necessary. The event caused or that could likely cause serious injury, harm, impairment, or death to residents of a nursing facility. Although both QASP and NHQI take crisis situations at nursing facilities seriously, neither program publicly lists the programs with severe care citations.

Funding Methodologies

Each of the pay for performance programs in California, New York, and Utah are funded with different methodologies. Generally, states rely on Medicaid and Provider fees to help fund their pay for performance programs. California's QASP has set aside $90 million for funding. New York's NHQI relies on a $50 million reduction of overall Medicaid payments for funding. Utah's QII program has set aside over $5 million for its QII(1) and QII(2) program. What remains from QII(1) and QII(2) payments is used to fund QII(3).

The funds for California's QASP are from several different sources. The three largest sources of funding include Assembly Bill 1629's Quality Assurance Fee (QAF), Penalties, and Professional Liability Insurance (PLI) Savings. The total from these funding sources is $90 million for QASP incentive and improvement payments.[22] The QAF is paid by nursing facilities and is matched with federal reimbursement dollars. The penalties are based on failing to meet staffing and quality standards. New York's NHQI is funded with the overall Medicaid reduction of $50 million annually.[23] Utah's QII relies on $5,275,900 set aside for the QII(1) and QII(2) programs. [24] Per a representative of Utah's QII program, 100% of the program's funding is from the state's general funds.

[21] www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/methodology.htm

[22] www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853

[23] http://leadingageny.org/home/assets/File/Comments%20on%202017%20Nursing%20Home%20Quality%20Initiative.pdf

[24] http://health.utah.gov/medicaid/stplan/NursingHomes/QI/FY17%20Quality%20Improvement%20Introduction%20Letter.pdf

5. BEST PRACTICES – LITERATURE REVIEW

A best practices literature review was conducted to gain a broader perspective on pay-for-performance programs and what aspects of these programs have shown to be most effective for better outcomes. Although there is no single way to design a Nursing Home pay-for-performance program for the best outcomes, based on literature, which includes independently conducted surveys, analysis, and policy research, there are certain program attributes that can be linked to the success and growth of such programs. In our research, many studies cited Iowa, Kansas, Minnesota, Oklahoma, Utah, and Vermont. Therefore, their program elements and results have been referenced in this section. The following summarizes the findings from our review of the different analyses.

Quality of Care

A common thread in literature regarding Nursing Home Pay for Performance relates to culture change. Mollot et al. state that state experiences suggest a clearer relationship between resident quality of care and financial incentives can go a long way in advancing quality of care.[25] In Iowa, a study showed that having extensive stakeholder involvement from industry representatives, advocacy groups, state agency personnel, and legislative staff allowed for clear definition of goals and allowed the state to pinpoint objective measures that directly correlated to resident quality of care and life.[26] Frequent check ins and updates with stakeholders helps to promote sustained buy-in.

There are P4P practices that don't rely solely on outcomes as a basis for quality of care. Structural measures like staffing can provide improvements upstream rather than simply focusing on down-stream outcomes. Mollot et al., in an assessment of pay of pay-for-performance programs at large, indicate that focusing on staff recruitment, orientation, and training and providing an incentive to be a top-tier employer can be used to attract top-talent as well as develop pre-existing talent.[27]

Furthermore, incorporating state inspections and making serious deficiency free surveys as well as strict regulatory compliance a part of quality of care domains can help improve quality of care. Miller et al.'s study of five states, indicates the use of deficiency free surveys as a pre-requisite for application (deficiency free surveys, regulatory compliance) and also includes staffing (nursing hours and turnover) and nationally reported quality measures.[28] Serious inspection deficiencies render homes ineligible for applications and publicly posting results can ensure homes handle upstream issues and moves states towards more regulatory focus.

Performance measures used in other settings should form the basis of nursing home performance measures.[29] Nursing homes likely treat residents with different types of issues, as such, risk adjustment for these measures should be incorporated for homes that treat more complex cases. [30] To ensure the limitation is mitigated, measures should be broad and span not only outcomes, but culture change as well.[31]

In a survey of six states, Arling et al. made note that if accountability is only held between the state and the nursing home(s) then improvement is not highly incentivized.[32] They go on to note that making information public and readily available promotes accountability. For example, Arling and his team suggest report cards, or another form of performance reports should be distributed not only to existing consumers, but made publicly available so potential residents and consumers can have information to make the best decision.[33]

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[25]www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf
[26]http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf
[27]www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf
[28]http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf
[29]oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new
[30]oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new
[31]oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new
[32]oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new
[33]oup.silverchair-cdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new

To summarize, early and frequent stakeholder engagement is a way to ensure that P4P programs keep quality of care in focus for different stakeholder groups. Additionally, flexibility with performance measures to capture the complex differences between residents and entire facilities should be put into place. Emphasizing a focus on regulatory compliance up front as well as initiating programs to recruit and train top-tier talent add to upstream best care quality practices. Finally, accountability adds a beneficial dimension by holding facilities accountable not just to themselves, but current and future consumers.

There are best practices that the Department had already implemented, such as a pre-requisite of results from a Colorado Department of Public Health and Environment survey to determine if a facility has any substandard deficiency and as a result would not be eligible to participate in the program. Additionally, the Colorado's program includes a measure on staff engagement to encourage retention.

Quality of Life

While care quality is important for ensuring the best health for residents, the fact remains that nursing homes act also as a main residence for many people. As such, there are practices that can ensure pay-for-performance measures incentivize improvements to the quality of life for residents. Much like performance measures being credible and easily researched, resident satisfaction surveys should be a part of measurements and should be performed by a third party. Additionally, they should remain anonymous.[34] Objectively selecting residents for surveys will help reduce sampling and measurement biases.

Literature suggests resident satisfaction surveys regarding person directed-care should have questions related to dining activities, resident choices, resident satisfaction (resident/family survey and complaint resolution), per Miller's study to determine[35] best practices from five nursing homes.[36] Miller et al. go on to state that while the responses can be subjective, response rates can be used as an objective measure.[37] Here, as stated before, it is important to make sure care is taken in administering and selecting a third party to carry out the survey. Resident satisfaction surveys with a response rate above a certain threshold can be used as a metric for points. The subjective nature in verifying certain quality of life areas (like menus and meal times) makes it difficult to verify information.

As noted earlier, some states, like Kansas, have seen marked improvements in Quality of Life measures through extensive focus on person centered care and culture change by placing extra emphasis and substantial financial incentives on homes that participate in the pay-for-performance program. In Kansas' program, structured training provides facilities with resources needed to formulate an action plan for implementing/improving person centered care in one of four areas (resident choice, homelike environment, empowering employees, and meaningful life.) An independent evaluator objectively evaluates progress.[38] Financial incentives increase as homes move through the program's five levels. A study performed indicated that participation in the pay-for-performance program rose in Kansas for both for-profit and not-for-profit facilities.[39] The improvement is measured by Kansas State university, and is done so annually; if improvement criteria are met, facilities move up a level and become eligible for more incentives. Additionally, an ongoing, independent study by the LeadingAge Center for Applied Research (CFAR) tracks quality of life improvements.

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[34] oup.silverchaircdn.com/oup/backfile/Content_public/Journal/gerontologist/49/5/10.1093/geront/gnp044/2/gnp044.pdfopen_in_new

[35] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf

[36] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf

[37] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf

[38] www.researchgate.net/profile/Linda_Hermer2/publication/316220929_The_Kansas_PEAK_20_Program_Facilitates_the_Diffusion_of_Culture-Change_Innovation_to_Unlikely_Adopters/links/58f66d370f7e9b67a34b88aa/The-Kansas-PEAK-20-Program-Facilitates-the-Diffusion-of-Culture-Change-Innovation-to-Unlikely-Adopters.pdf

[39] www.researchgate.net/profile/Linda_Hermer2/publication/316220929_The_Kansas_PEAK_20_Program_Facilitates_the_Diffusion_of_Culture-Change_Innovation_to_Unlikely_Adopters/links/58f66d370f7e9b67a34b88aa/The-Kansas-PEAK-20-Program-Facilitates-the-Diffusion-of-Culture-Change-Innovation-to-Unlikely-Adopters.pdf

Improvements in quality of care and quality of life do not happen in a vacuum, benefits from culture change improvements in quality of life areas can also seep into quality of care. Additionally, the most common traits for high performing pay-for-performance programs is giving facilities the choice in not only who performs the customer satisfaction measurements, but how they demonstrate commitment to quality of life and person centered care. This flexibility allows facilities to ease into a new culture and empowers facilities by giving them flexibility to target the cultural and quality of life areas as they see fit.

Overall, the Department has emphasized on the best practices found in pay-for-performance program literature. Colorado's application includes several measures focused on person centered care that include creating a homelike environment, facilities improvement, connection and meaning, and volunteering. The Department also includes a resident/family satisfaction survey as a pre-requisite.

Facility Management

While not commonly a major focus in pay for performance programs, facilities management remains important. By setting aside funds for capital improvement projects, Utah gives facilities the option of focusing on certain capital improvements that improve quality in the home.[40] The facilities do, as Miller states, need to prove that they paid for the improvements to receive any portion of the funds, additionally, the funds are distributed in a fixed amount per Medicaid bed.[41]

By allowing facilities to choose the focus of their capital improvement projects they can take on improvements at their own pace and focus on areas they prescribe as important. Utah has several categories like nursing station, lifts, EHR, bathing systems, quality training, and dining systems.[42] The list, per a study by Miller and his team, is scheduled to add areas of improvement year over year to provide more options.

Recommendation 11*: Consider including a risk adjustment factor in calculating points for quality measures to account for facilities that may have residents with more complex conditions. This encourages nursing homes to address the unique needs of their residents and provides a more accurate comparison of nursing home performance.*

Recommendation 12: *Continue to collect data on the resident/family satisfaction survey prerequisite and consider offering facilities the opportunity to earn extra points for submitting a resident/family satisfaction survey with a response rate above a certain threshold. This would align with the current measure on the staff satisfaction survey along with national best practices.*

[40] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf
[41] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf
[42] http://faculty.cbpp.uaa.alaska.edu/afgjp/PADM601%20Fall%202013/Pay%20for%20Performance%20in%205%20states.pdf

6. CMS 5-STAR RATING DATA REVIEW

At the national level, CMS has a rating system to allow consumers, families, and caregivers to compare nursing homes. CMS has acknowledged the difficulty of developing a rating system that addresses all considerations that consumers and families may have when deciding on a nursing home. The rating system described below is meant to be one source of information that should be considered with other factors to best inform a decision on a nursing home for an individual.

CMS employs a 5-star rating system, as such, overall ratings range from one star to five stars, with more stars indicating better quality. As described by CMS, the 5-star ratings are based on the three components listed below. Each component gets its own rating, then an overall rating is determined.

1) Health inspections: this includes reviewing information from the previous three years of onsite inspections that include standard and complaint surveys.

2) Staffing: this includes reviewing information regarding the average number of hours of care provided to each resident each day by nursing staff.

3) Quality measures (QMs): this includes reviewing 11 different physical and clinical measures for nursing home residents.

Using the three components, CMS assigns the **overall 5-star rating** in these steps:

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.

Out of the 128 applications received, 15 (12%) had a 1-star rating, 16 (12%) had a 2-star rating, 18 (14%) had a 3-star rating, 33 (26%) had a 4-star rating, and 46 (36%) had a 5-star rating. It can be determined that a 1 or 2-star rating did not deter facilities from applying for the 2017 pay-for-performance program. The increase in percentage across the star ratings is likely due to assumed high-performance on the application because of a high 5-star rating.

Furthermore, looking at average final scores and (range) across the star ratings the average final application score for 1-star facilities is 44.2 (range: 15-66), 2-star facilities is 51.7 (range: 24-73), 3-star facilities is 60.5 (range: 25-85), 4-star facilities is 58.4 (range: 0-90), and 5-star facilities is 56.6 (range: 0-93). The top scores within each star level range increase as the rating level increases. However, based on the average scores and the wide ranges, star rating is not a predictor of success on the P4P application.

Self-score can be telling about assumed high application performance based on star rating. 1-star facilities, on average, had a self-score of 53.7 (range: 21-76), 2-star facilities had an average self-score of 69.3 (range: 24-91), 3-star facilities had the highest average self-rating by a slim margin with a score of 72.9 (range: 34-85), 4-star facilities had an average self-score of 72.6 (range: 25-96), and 5-star facilities had an average self-score of 72.7 (range: 31-94). Facilities with 3-star ratings and above had average scores between 72-73 points, indicating that

overall, these facilities expected to perform well on the P4P application given a high-performance and thus applied for more points, compared to the 1-star and 2-star facilities, on average.

Additional in-depth conclusions are difficult to draw given the optional nature of not only the application, which skews available sample size for each 5-star rating level, but of the various components of the application. Additionally, many measures have an all or nothing points calculation, meaning that if a facility is missing or deficient in one factor or requirement of a measure, they do not receive any related points. This works in two directions: either facilities apply for as many measures as possible, assuming that because they performed highly on the 5-star rating system, they would receive points on the P4P application; or facilities apply only for the measures that they have complete certainty they will receive points on considering deficiencies associated to the 5-star rating system, as seen in 1-star and 2-star facilities self-scores.

The table that follows lists nursing homes that participated in P4P this cycle and compares the home's self-score, final review score, and the CMS 5-star rating.

Facility Name	2017 Self Score	2017 Final Review Score	5-Star Rating
ALPINE LIVING CENTER	66	66	1
APPLEWOOD LIVING CENTER	48	44	1
BELMONT LODGE HEALTH CARE CENTER	48	44	1
CEDARWOOD HEALTH CARE CENTER	50	41	1
CHEYENNE MOUNTAIN CENTER	51	27	1
DEVONSHIRE ACRES	76	61	1
ELMS HAVEN CENTER	21	15	1
FORT COLLINS HEALTH CARE CENTER	51	46	1
GUNNISON VALLEY HEALTH SENIOR CARE CENTER	24	22	1
MINNEQUA MEDICENTER	54	38	1
PARKMOOR VILLAGE HEALTHCARE CENTER	81	58	1
SIERRA VISTA HEALTH CARE CENTER	51	51	1
SPRING CREEK HEALTH CARE CENTER	61	41	1
TERRACE GARDENS HEALTH CARE CENTER	61	53	1
WINDSOR HEALTH CARE CENTER	63	56	1
ASPEN LIVING CENTER	62	56	2
BERTHOUD LIVING CENTER	80	71	2
BETH ISRAEL AT SHALOM PARK	82	73	2
BOULDER MANOR	24	24	2
BROOMFIELD SKILLED NURSING AND REHABILITATION CTR	53	37	2
COLONIAL COLUMNS NURSING CENTER	80	46	2
HIGHLINE REHABILITATION AND CARE COMMUNITY	71	71	2
JUNIPER VILLAGE - THE SPEARLY CENTER	78	55	2
LA VILLA GRANDE CARE CENTER	64	41	2
PUEBLO CENTER	75	56	2
REHABILITATION CENTER AT SANDALWOOD	91	72	2
RIVERWALK POST ACUTE AND REHABILITATION	75	38	2
SANDROCK RIDGE CARE AND REHAB	68	53	2
TRINIDAD INN NURSING HOME	75	31	2

Facility Name	2017 Self Score	2017 Final Review Score	5-Star Rating
VALLEY MANOR CARE CENTER	76	48	2
VISTA GRANDE INN	54	55	2
ASPEN CENTER	76	28	3
AVAMERE TRANSITIONAL CARE AND REHABILITATION-MALLEY	72	50	3
CEDARS HEALTHCARE CENTER	70	60	3
CHERRELYN HEALTHCARE CENTER	78	62	3
COLOROW CARE CENTER	83	85	3
FOUR CORNERS HEALTH CARE CENTER	84	80	3
GOOD SAMARITAN SOCIETY - BONELL COMMUNITY	81	81	3
HALLMARK NURSING CENTER	63	63	3
HARMONY POINTE NURSING CENTER	71	69	3
HEALTH CENTER AT FRANKLIN PARK	79	60	3
HILDEBRAND CARE CENTER	75	77	3
KENTON MANOR	83	83	3
MOUNTAIN VISTA HEALTH CENTER	34	25	3
PARKVIEW CARE CENTER	80	64	3
PEARL STREET HEALTH AND REHABILITATION CENTER	85	66	3
RIO GRANDE INN	67	52	3
SKYLINE RIDGE NURSING AND REHABILITATION CENTER	59	40	3
SPRINGS VILLAGE CARE CENTER	72	44	3
ALLISON CARE CENTER	78	74	4
AMBERWOOD COURT REHABILITATION AND CARE COMMUNITY	89	90	4
AUTUMN HEIGHTS HEALTH CARE CENTER	67	64	4
BENT COUNTY HEALTHCARE CENTER	75	69	4
CAMBRIDGE CARE CENTER	82	82	4
CENTENNIAL HEALTH CARE CENTER	81	81	4
CENTURA HEALTH-MEDALION HEALTH CENTER	42	37	4
CHERRY CREEK NURSING CENTER	82	53	4
CHRISTOPHER HOUSE REHABILITATION AND CARE COMMUNITY	96	88	4
CLEAR CREEK CARE CENTER	70	65	4
COLORADO STATE VETERANS HOME AT FITZSIMONS	36	27	4
COTTONWOOD CARE CENTER	78	72	4
EBEN EZER LUTHERAN CARE CENTER	77	75	4
ENGLEWOOD POST ACUTE AND REHABILITATION	25	17	4
GARDEN TERRACE ALZHEIMER'S CENTER OF EXCELLENCE	48	43	4
GOLDEN PEAKS CENTER	96	73	4
GRACE MANOR CARE CENTER	84	25	4
HOLLY NURSING CARE CENTER	77	76	4
JEWELL CARE CENTER OF DENVER	86	80	4
JULIA TEMPLE HEALTHCARE CENTER	85	81	4
LAMAR ESTATES LLC	84	40	4

Facility Name	2017 Self Score	2017 Final Review Score	5-Star Rating
MANORCARE HEALTH SERVICES - BOULDER	59	43	4
MANORCARE HEALTH SERVICES - DENVER	48	0	4
MESA MANOR CENTER	88	73	4
NORTH STAR REHABILITATION AND CARE COMMUNITY	82	69	4
PAVILION AT VILLA PUEBLO, THE	84	51	4
PEAKS CARE CENTER THE	59	28	4
ROWAN COMMUNITY, INC	75	69	4
SIERRA REHABILITATION AND CARE COMMUNITY	80	76	4
SUNSET MANOR	68	50	4
VALLEY INN, THE	87	85	4
VALLEY VIEW HEALTH CARE CENTER INC	74	51	4
WILLOW TREE CARE CENTER	55	19	4
ARVADA CARE AND REHABILITATION CENTER	65	28	5
BERKLEY MANOR CARE CENTER	31	5	5
BRIARWOOD HEALTH CARE CENTER	70	69	5
BROOKSHIRE HOUSE REHABILITATION AND CARE COMMUNITY	86	86	5
BROOKSIDE INN	80	80	5
BRUCE MCCANDLESS CO STATE VETERANS NURSING HOME	61	54	5
CHRISTIAN LIVING COMMUNITIES SUITES AT SOMEREN GLEN CARE CENTER	70	51	5
COLORADO LUTHERAN HOME	77	72	5
COLORADO VETERANS COMMUNITY LVG CTR AT HOMELAKE	83	68	5
COLUMBINE WEST HEALTH AND REHAB FACILITY	69	51	5
COTTONWOOD INN REHABILITATION AND EXTENDED CARE CENTER	61	34	5
DENVER NORTH CARE CENTER	86	68	5
E DENE MOORE CARE CENTER	91	63	5
EAGLE RIDGE OF GRAND VALLEY	83	71	5
FAIRACRES MANOR, INC.	81	85	5
FOREST STREET COMPASSIONATE CARE CENTER	64	40	5
GOOD SAMARITAN SOCIETY - FORT COLLINS VILLAGE	75	37	5
GREEN HOUSE HOMES AT MIRASOL, THE	75	71	5
HILLCREST CARE CENTER	77	41	5
HOLLY HEIGHTS CARE CENTER	94	93	5
HORIZONS CARE CENTER	69	54	5
LARCHWOOD INNS	65	58	5
LAUREL MANOR CARE CENTER	71	66	5
LIFE CARE CENTER OF GREELEY	42	13	5
LIFE CARE CENTER OF LONGMONT	73	51	5
LINCOLN COMMUNITY HOSPITAL NURSING HOME	69	50	5
MANTEY HEIGHTS REHABILITATION AND CARE CENTER	75	65	5
MESA VISTA OF BOULDER	80	75	5
MONTE VISTA ESTATES LLC	81	46	5

Facility Name	2017 Self Score	2017 Final Review Score	5-Star Rating
MOUNT ST FRANCIS NURSING CENTER	83	83	5
NORTH SHORE HEALTH AND REHAB FACILITY	64	38	5
PARK FOREST CARE CENTER, INC.	68	38	5
PIKES PEAK CENTER	81	48	5
PINE RIDGE EXTENDED CARE CENTER	78	56	5
ROCK CANYON RESPIRATORY AND REHABILITATION CENTER	80	55	5
SPANISH PEAKS VETERANS COMMUNITY LIVING CENTER	78	78	5
ST PAUL HEALTH CENTER	86	69	5
SUITES AT CLERMONT PARK CARE CENTER	58	58	5
SUMMIT REHABILITATION AND CARE COMMUNITY	80	82	5
SUNNY VISTA LIVING CENTER	75	62	5
VALLEY VIEW VILLA	42	28	5
VILLA MANOR CARE CENTER	57	0	5
WALSH HEALTHCARE CENTER	78	65	5
WESTERN HILLS HEALTH CARE CENTER	67	52	5
WESTLAKE CARE COMMUNITY	86	82	5
WHEATRIDGE MANOR CARE CENTER	80	66	5

7. RECOMMENDATIONS

A summary of the recommendations and considerations outlined in this report are as follows:

Recommendation 1: Continue to review each measure and minimum requirement in the application. Ensure the P4P Committee, providers, the Department, and review team are clear on all minimum requirements and documentation submission requirements. Provide examples, as applicable, of what should be submitted so all parties are on the same page.

Recommendation 2: Develop and approve clear review standards based on the application minimum requirements between the Department and review team. Identify any questions early in the submission and review process and communicate decision points and standards to all parties.

Recommendation 3: Review and revise submission requirements for qualitative and quantitative measures. Determine any minimum requirements requesting substantial information. Identify any reports or data that can be obtained by the Department (i.e. CASPER reports) and reviewed by the review team. This would simplify the application process for the nursing homes and may encourage participation in the program. Furthermore, this eases the administrative load on administrators and managers who can then focus on ensuring they meet other application measures.

Recommendation 4: Consider a multi-phase application submission process that would help reduce the administrative burden for providers and provide multiple opportunities to submit supporting documentation as part of the application.

Recommendation 5: Review and prioritize system enhancements to help improve the application submission and review processes.

Recommendation 6: Continue to expand on outreach and training activities to further emphasize application requirements and submission best practices. For example, creating a short checklist of the most important points for a complete application.

Recommendation 7: Conduct a short web survey to gather additional insight and experiences from a broad group of nursing facilities. With changes made to the program each year and the maturity of the program, this may be an ideal time to have a more holistic evaluation of the program from the provider-level. The survey can drive participation and engagement of the nursing facilities.

Recommendation 8: Ensure the provider contact list is updated throughout the year and has the most up to date information for each participating home as the application process begins allowing maximum time to submit an application.

Recommendation 9: Continue to monitor the progress of the SNFVBP Program, particularly as the measure moves incentivizing potentially preventable readmissions and adjusting scores to account for patient differences across facilities. This measure should be communicated to the P4P Committee and to the nursing homes at provider trainings with the expectation of incorporating this measure as part of the 2019 program year application, to get

ahead of Fiscal Year 2019. In addition, consider following the program's application process of not requiring additional reporting from facilities for data that can be obtained and calculated by the Department.

Recommendation 10: Reward facilities that engage in multidisciplinary care planning activities or preventative care training, particularly to address the common reasons for patient hospital admissions and readmissions. This would improve quality of care for patients while promoting facilities to proactively educate staff on the most concerning health conditions.

Recommendation 11: Consider including a risk adjustment factor in calculating points for quality measures to account for facilities that may have residents with more complex conditions. This encourages nursing homes to address the unique needs of their residents and provides a more accurate comparison of nursing home performance.

Recommendation 12: Continue to collect data on the resident/family satisfaction survey prerequisite and consider offering facilities the opportunity to earn extra points for submitting a resident/family satisfaction survey with a response rate above a certain threshold. This would align with the current measure on the staff satisfaction survey along with national best practices.

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