Colorado Department of Health Care Policy and Financing

2018 Nursing Facilities Pay for Performance Application Review

Recommendations Report

July 11, 2018

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 2018 (calendar year 2017) Pay for Performance (P4P) program year. This Recommendations Report is supplemental to the 2018 P4P Data Report, which includes final scores, historical data analysis, and a measure by measure data breakdown. This report provides analysis and recommendations for the P4P Program application and process to help ensure continuous program improvement. Considerations for the Department to implement in the P4P Program are 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.

Each section offers specific details on the focus areas identified above and provides recommendations related to the findings and observations.

2. P4P PROGRAM REVIEW

The Colorado P4P Program has continued to evolve and the 2018 application cycle marked the second year a web portal was used by nursing homes to complete and submit applications. The experience and feedback from the inaugural year were used as opportunities to enhance the web portal application to improve user experience from both the applicant and reviewer perspective. Additionally, improvements in measures, minimum requirements and scoring were also updated in the 2018 application. Overall, year after year, the Department has implemented changes to the application and process that address improving clarity, increasing participation, easing administrative burden and encouraging nursing homes to improve on key quality measures in Colorado.

Each P4P application year is unique, therefore this section reports on the following:

- noted observations throughout the review process,
- collected feedback from the Department and providers on the application and review process; and,
- analysis of the final scores and measure analysis.

From the information collected above, PCG has outlined opportunities for further application, process, and program refinement.

2.1 P4P Application

Minimum Requirements Specificity and Standards

Language for the minimum requirements continues to be open to interpretation from both the application and reviewer perspectives. While this may not always be completely avoidable, there have been patterns observed from the 2018 application that point to where a minimum requirement language discrepancy should be addressed. There were three measures in which a facility assessment was referenced in the minimum requirement. These minimum requirements did not specifically state for facilities to submit their facility assessments but rather apply findings from the assessment to the measure content.

Table 1 displays three examples of minimum requirements that reference facility assessments. As including facility assessment information was the basis for these minimum requirements, reviewers found the level of detail and direct reference to the facility assessment varied greatly between nursing homes. Applicants also may have believed that it is a readily apparent that writing a narrative on specific activities and training was based on the facility assessment since the minimum requirement did not state to identify specific data.

Table 1. Examples of Facility Assessment Minimum Requirement Language

Measure	Minimum Requirements
Enhanced Dining	Evidence that your menu and dining atmosphere is based upon your facility assessment.
Connection and Meaning	Based upon the completed facility assessment, describe what opportunities you have identified to provide connection and meaning to your residents that reflects the unique cultural, ethnic and religious needs of the community. In addition, describe how you incorporated those opportunities to foster the connection and meaning into the resident's daily lives.
Continuing Education	Provide a detailed narrative discussing how your facility assessment influenced the qualified (as defined in Appendix 2) continuing education provided to your staff over the previous calendar year.

Recommendation 1: Clarify language so both applicants and reviewers have the same expectations of what is acceptable as supporting documentation. For example, "based upon the facility assessment" could be more instructive if re-worded to state "describe information from the facility assessment and how it applies to [X measure]".

A significant change to the minimum requirements this year was that nursing homes were no longer required to submit dated testimonials; however, the testimonials should still speak to experiences from the calendar year under review. While this was a significant improvement, there are still ways to further refine the language around required testimonials:

- *Signed versus unsigned testimonials*: only one measure, Enhanced Dining, required including "signed testimonials" while seven other measures simply required "testimonials". This inconsistency can be overlooked by both reviewers and applicants.
- *Defining what qualifies as a testimonial*: the vast majority of applicants submitted, when required, testimonials written by residents, but there were instances when testimonials were written by a staff on behalf of the member, therefore told in third party point of view. Applicants that submitted testimonials in this format later clarified that some residents are no longer able to write, but could still voice their perspectives and wanted to provide their feedback in the application.

Recommendation 2: Keep minimum requirements language consistent if they are requesting the same type of supporting documentation. All minimum requirements related to testimonials should be required to be "signed" or "unsigned". Furthermore, provide a clear definition of what qualifies as an acceptable testimonial.

Supporting Documentation & Administrative Burden

Feedback from nursing home staff during the on-site reviews included words of appreciation that the application was noticeably less administratively burdensome. For example, the Daily Schedules and Care Planning measure, only requires applicants to submit four care plans as opposed to ten in the previous year. There are a couple of measures where the Department can further reduce the amount of supporting evidence that needs to be uploaded, while still receiving sufficient evidence to validate the nursing home meets the measure requirements. Two examples of this are measures that appear to require redundant evidence. For both measures below, an applicant could provide the same document twice to meet multiple minimum requirements. This is extra work for the nursing home and can be confusing for reviewers.

Table 2. Examples for Reducing Redundancies

Measure	Minimum Requirements (issue in bold/italics)
Enhanced Dining	01.4- Evidence that these options ***included input from a resident/family advisory group such as resident council or a dining advisory committee*** that takes into account the cultural, ethnic and religious needs of the resident population. 01.8- Supporting documentation can be resident signed testimonials***,*** ***resident council minutes, minutes from another advisory group*** and photographs of changes in the dining atmosphere.
Enhanced Personal Care	02.3- ***Evidence that the bathing atmosphere includes home décor.*** 02.7- Documentation must ***include color photographs of the décor associated with the enhancements***.

Recommendation 3: Identify minimum requirements within measures that request essentially identical or interchangeable supporting documentation. Applicants either upload more documents than necessary or upload the supporting documentation for only one of the minimum requirements, which the reviewer may see as insufficient for meeting both minimum requirements.

A significant addition to the 2018 application was a minimum requirement to include a narrative for a home's three lowest scored Quality Measure for measure set 16. Nationally Reported Quality Measures Scores. There were two key findings regarding this minimum requirement.

1. *Interpretation of "lowest scored"*: some applicants interpreted lowest scored as the three lowest percentile measures of the eight scored Quality Measures, some as the the three lowest performing scores of all the measures in the CASPER reports, and others as the three lowest rate percentile measures of all the measures in the CASPER reports. Reviewers initially marked these instances as not meeting the minimum requirement as the three "lowest scored" should be those with the highest percentiles of the eight Quality Measures included in the application. However, as the language could have been further clarified and there was also initial misinterpretation on the reviewer side, PCG re-reviewed these measures and did not penalize applicants who interpreted the minimum requirement in the ways described above.
2. *Weight of the Quality Measures narrative*: this narrative was required for the eight measures tied to Nationally Reported Quality Measures Scores and only needed to be submitted once. This meant that if the narrative minimum requirement was not met, points were lost for all eight measures. This obviously could have significant impact on an applicant's final score.

Recommendation 4: One piece of supporting documentation should not impact multiple measures as an applicant who has an issue with this one document can lose a significant amount of points. Reconsider the weight the Nationally Reported Quality Measures Scores Narrative has on earning points for the eight Quality Measures.

2.2 Application Process

Web Portal

As mentioned previously, this was the second year that the entire P4P application was completed, submitted and reviewed via an online web portal. To build upon the overall success of the online system application last year, enhancements were made to further promote user experience. This included the functionality to upload documents to a specific minimum requirement which allowed the applicant to validate that supporting documentation was provided for each of the individual minimum requirements. However, applicants still had the option to upload documentation pertaining to all minimum requirements within a measure as one document. Additionally, the web portal now has a time out period of 30 minutes as opposed to 15 minutes from the previous year. Homes also receive confirmation submission emails after submitting their application successfully.

Further system development can be considered to streamline the application and review process. The following improvements have been gathered from nursing home and reviewer feedback:

- Allowing a facility to have multiple user accounts with access to the web portal or to have one user with access to multiple facilities' applications;
- Updating the upload functionality to enable the nursing home to see past the first few documents uploaded during the upload process; and,
- 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.

Recommendation 5: Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.

Preliminary Review Process

This year's review process included a preliminary review which included identifying instances in which a home may have unintentionally forgot to upload a document or uploaded CASPER reports for the incorrect reporting periods. The nursing home would then be given the opportunity to update their application before the final review period commenced. The preliminary review, as indicated by its name, is not a comprehensive review, therefore is only meant to catch clear instances of application oddities. It is still each nursing home's responsibility to review their application for completeness and accuracy.

Overall, the preliminary review found at least one finding for 58 facilities, thus gave nursing homes the chance to resubmit their application with the appropriate documents and earn points that otherwise would have been lost. However, as this was the first year the preliminary review was implemented, there were lessons learned on how to improve the process. For example, applicants did not appear to know that the preliminary review was a part of the overall review process this year or did not understand what it entails. PCG received many questions from homes with preliminary review findings and received appeals that included misinterpretations of the process. Communication regarding the preliminary review process and what it encompasses can continue to be emphasized during the next application year through emails and trainings.

Recommendation 6: Consider adding a review timeline message into the automated submission email that the system currently sends when a facility submits an application. This message would highlight the preliminary review, the results notification letters, and appeals period. A brief description of each phase of the review and their associated timeline would be included in this automated message which would lead applicants to have a better understanding of review processes and expectations.

2.3 Program Development and Participation

The number of P4P applicants has remained consistent with between 127-129 nursing homes applying for the past four years. In 2018, this number slightly increased to 130 applicants. The P4P web portal indicates that there are 195 nursing homes with accounts to access the portal. There may be a number of reasons the 65 nursing homes with an account did not complete and submit an application. Possibilities include not meeting the pre-requisites, particularly regarding substandard deficiencies. The application states "No home with substandard deficiencies, as defined in State Operations Manual, during the previous calendar year will be considered for the current P4P application." Additionally, a nursing home may choose not to apply for the P4P program as they may believe they would not obtain enough points to receive any per-diem add on. Nonetheless, the Department could conduct a short survey to obtain clear reasons why these nursing homes did not participate. This may be an opportunity for the Department to expand outreach and consider feedback that would encourage greater participation statewide.

Recommendation 7: Reach out to nursing homes that have created an account on the web portal but did not submit an application in the 2018 P4P program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.

The application period naturally comes with many questions from nursing homes who intend to submit applications. Questions range from technical or programmatic to general inquiries. For the past years, PCG has used general staff emails for communications, however the volume of emails from P4P applicants to a general staff email during the peak application season can be difficult to streamline which can lead to delays in responses or unintentionally missing emails. As the P4P program continues to mature, particularly with the web portal, a program specific email would ensure that reviewers and technical staff can always access historical program related emails. This would also provide security to nursing homes that their emails are being sent to the appropriate contact.

Recommendation 8: Create a dedicated email for the P4P program. Application inquiries and technical issues can all be routed to this email. Any emails that currently go to the Department can continue to do so, including appeals and specific program questions.

3. CMS SNF REVIEW

The Centers for Medicare and Medicaid Service (CMS) continues to promote initiatives and innovations to improve quality of care at skilled nursing facilities (SNF). One CMS initiative of note is the Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP), which was authorized by Section 215 of the 2014 Protecting Access to Medicare Act (PAMA). PAMA includes details about the readmission measures for the program, how facilities will be scored, the performance standards and periods, how facilities can review their scores and how performance will be reported to the public.

The SNF VBP's goal is to support improved clinical outcomes and experiences for skilled nursing facility patients. This program will reward participating skilled nursing facilities based on measures associated with hospital readmissions.

Specifically, the measure that CMS will be utilizing is the:

- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM): "This measure estimates the risk-standardized rate of unexpected hospital readmissions within 30 days for people with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals and for any cause or condition."[1]

CMS provided a fact sheet[2] regarding SNFRM that provides further insight on how the measure will be used in this program:

- "Hospital readmissions will be identified through Medicare claims. This means that SNFs do not have report any additional data to CMS;
- Unplanned admissions are identified using a modified version of the CMS Planned Readmissions Algorithm;
- The SNFRM is adjusted to account for patient differences, such as comorbidities, when comparing facility readmission rates; and
- CMS will propose to replace the SNFRM with the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) in future rulemaking."

Starting in FY2019, all SNF that are paid under the SNF Prospective Payment System (SNF PPS) will be eligible to receive incentive payments under the SNF VBP. The incentive payments will be funded by a two percent reduction in the adjusted Federal per diem rate paid to SNFs for the FY. 60 percent of this withheld amount will represent the total available funding for the incentive payments.[3] Nearly all Colorado P4P SNFs are participating in the SNF VBP.[4]

For the FY2019 program, the performance period that is being evaluated is CY17 (January 1-December 31, 2017) while CY15 (January 1-December 31, 2015) will serve as the baseline period. CMS will utilize the SNFRM to evaluate if there was any improvement between CY17 and CY15. SNFs will receive a score based on both their improvement and achievement between the baseline and performance year. CMS will use these scores to develop incentive multipliers. Those SNFs that earn higher scores will receive higher incentive payments than lower performing peers. Incentive payments will be dispersed in October 2018.[5] SNFs with performance scores that are

[1] https://www.cms.gov/Medicare/ Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-things-to-know-about-SNFRM.pdf
[3] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf
[4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-Public-Reporting-Oct-2017.xlsx
[5] https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-11-16-SNF-VBP-Presentation.pdf

ranked in the lowest 40% nationally will receive payments at a rate lower than they would have without the SNF VBP.[6]

Recommendation 9: ***As preventable hospital readmissions are the primary focus in SNF VBP we suggest reevaluating how hospitalizations are currently scored in the Colorado P4P program. One consideration is to include a year to year improvement threshold for facilities who have hospitalization rates below the national average but can still qualify for points as opposed to receiving points for any improvement.***

Recommendation 10: Continue to develop measures within the P4P tool that do not require additional or redundant reporting from facilities for data. Instead, build measures where facility-level data can be obtained and calculated by the Department from validated sources like CMS.

[6] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf

4. OTHER STATES REVIEW

Colorado's P4P program is well established and collaboration throughout the year with nursing home administrators is conducive to continuous improvement. Still, it can be useful for the Department to stay informed of other state's P4P-like programs. This section provides the Department with such information in two ways: we gather research from two additional states' programs and include a summary of findings from the previous two P4P Recommendation Report that are still relevant and may be instructive for any program changes.

OKLAHOMA

On July 1, 2007, the Oklahoma Health Care Authority (OHCA) implemented the Focus on Excellence program which is designed to measure and ensure the integrity, quality and overall wellness of consumers and Long-Term Care (LTC) facilities. Every LTC facility in Oklahoma is able to participate in the program and there are currently 290 actively participating facilities. The program has two components, an incentive methodology tied to nursing facility performance against defined quality criteria and a star rating system published on a website accessible to consumers. Both rely on the eleven quality measures:

- Quality of Life
- Resident/Family Satisfaction
- Employee Satisfaction
- System-wide Culture Change
- Certified Nursing Assistant/Nursing Assistant Turnover Retention
- Nurse Turnover and Retention
- State Survey Compliance
- Clinical Measures
- Nursing Staffing per Patient Day
- Overall Occupancy (used on website only)
- SoonerCare (Medicaid) Occupancy and Medicare Utilization (used as incentive payment methodology only)

All of these measures were meant to encompass three different areas of satisfaction: the resident, family, and employee.

Quality of Life

OHCA uses My InnerView as its program vendor, which used a single survey instrument to collect data on quality of life. Surveys were circulated to nursing facilities for distribution to all residents within the facility, no matter the type of payer they were associated with. Respondents have four choices of answers: either agree strongly, agree, disagree, or disagree strongly. If a resident is unable to do so on their own, a family member or other responsible party is able to help them. Family members also complete the survey, which is mailed to their homes and returned directly to My InnerView. The survey asks about four different areas, one being Quality of Life. The different quality of life measures include:

- Choices/preferences
- Respectfulness of staff
- Respect for privacy
- Resident-to-staff friendships
- Resident-to-resident friendships
- Meaningfulness of activities
- Religious/Spiritual Activities
- Safety of facility
- Security of personal belongings
- Quality of dining experience

In order for an individual's response to be considered valid and included in the facility's quality of life rating, a respondent must answer at least four of the ten questions. Survey responses are averaged across all quality of life items to arrive at an overall facility rating for satisfaction.

Quality of Care

Part of OHCA's common objective is to use a combination of financial incentives and public disclosure to improve the quality of care. One of OHCA's primary objectives for the "Focus on Excellence" program is to develop a pay for performance mechanism that creates incentives for nursing homes to maintain and improve quality of care. My InnerView receives data on facility direct care staffing hours from the OHCA monthly. Facilities are required to submit the data to the OHCA on a Quality of Care report which is used to calculate the ratio of Medicare Part A days to Medicaid days. The different Quality of Care Measures include:

- Quality of RN/LVN/LPN care
- Quality of CAN/NA care
- Quality of rehabilitation therapy
- Adequate staff to meet needs
- Attention to resident grooming
- Commitment to family updates
- Competency of staff
- Care (concern) of staff

Quality of Care is an important area of focus for nursing facilities as the states believes if staff is not happy, educated, and getting enjoyment from the environment, this will not translate to quality care for its residents.

GEORGIA

Georgia's Department of Community Health (DCH) decided to take part in the Nursing Home Quality Initiative where they implemented a pay for performance program. DCH decided that it would give 78 percent of the Medicaid participating nursing homes that met or exceeded specific quality performance standards a pay for performance incentive. This program requires collaboration from the Department of Community Health, nursing home providers, and consumer groups to raise the quality of care for the 40,000 Georgia citizens who live in the state's nursing homes. Some examples of Georgia's quality measures are as follows[7]:

- Prevalence of acquired decubiti (occurred after patient in NH)
- Use of psychotropics
- Use of physical restrains
- Prevalence of falls
- Use of Catheters
- Occurrence of depression
- Survey deficiency analysis
- Staff Stability

Quality Staff

Nursing home facilities participating in Georgia's program should have a plan that has specific measurable strategies for staff selection, training, and retention. The facilities standards should at the very least meet the following[8]:

[7] http://www.commonwealthfund.org/usr_doc/Kuhmerker_P4PstateMedicaidprogsappendixB.pdf?section=4039
[8] https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/23/32/32718337Nursing%20Facilities.pdf

- Developing professional and direct care staff by offering continuing education/training
- Ensuring that the documented costs of personnel are accurately reflected in the proforma and cost projections
- Providing documentation that all staff, particularly those who will provide the proposed services, possess state licensure's specified levels of education, credentials, experience and training to provide high quality services
- Demonstrating the organization's intent to obtain appropriate levels and numbers of professional and paraprofessional staff to meet the requirements of the proposed services, and that the specified personnel are available in the proposed geographic service area

Similarly to OHCA, the DCH used nursing home performance information through My InnerView to determine the quality incentive payments. My InnerView has research showing that state nursing homes that take place in the statewide quality initiative actually achieve results, such as reducing resident falls, the use of physical restraints and antipsychotic medications, and reduction in staff turnover rates.

According to Georgia's Department of Community Health in FY 2009:

- Nursing facility services totaled 1.14 billion and accounted for 17 percent of all Medicaid benefits expenditures.
- Georgia Medicaid paid for nursing home care for 40,887 recipients, which equals 2 percent of all Medicaid recipients. Medicaid pays for the care of approximately 74 percent of all nursing home residents in the state.
- Per recipient expenditures averaged $26,522 for intermediate or skilled care in a nursing home and $89,347 for an intermediate care facility for people with mental retardation. (Per recipient averages do not represent the average annual cost of nursing home care, since some recipients receive care for less than a full year.)

In 2009[9], DCH continued the incentive fee program for nursing facility providers who met specific criteria for quality measures, adding a 1 percent additional increase to the incentive payment through legislative mandate that began in FY 2010. Over 89 percent of all facilities participating in the program were awarded the incentive fees.

SUMMARY OF PREVIOUS INFORMATION COLLECTED ON OTHER STATES' PROGRAMS

California

California's Quality Accountability Supplemental Payment Program (QASP) has been in operation since 2014 due to the passage of SB 853.[10] 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.[11] In other words, QASP rewards yearly improvement in facilities.

[9] https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/3/39/167346932FY09AnnualReportredu.pdf
[10] http://www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853
[11] http://www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853

New York

New York has participated in a nursing facility pay for performance program since 2008.[12] 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 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

Utah

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program is the name of the state's pay for performance program.[13] 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.

Recommendation 11: Explore dedicating funds for rewarding nursing homes who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from submitting an application. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.

[12] http://www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf
[13] http://health.utah.gov/medicaid/stplan/NursingHomes/QI/UHCA_April_2017_Presentation.pdf

5. BEST PRACTICES

In our review of best practices this year, PCG focused specifically on payment mechanisms that are used to promote improved quality at nursing homes. PCG's research concluded that more states are utilizing alternative payment methodologies to reward quality, specifically there is a clear trend of implementing value-based payments. Typically, these payments are tied to specific services or quality measures. PCG selected three states that have recently updated their nursing home quality incentive programs. Arizona and Ohio have implemented value-based payment (VBP) methodologies and New York has recently enacted legislation that reduces Medicaid revenue to nursing homes that rank the lowest on quality initiative measures. Similar to the previous section, PCG reviewed Recommendations Reports from the previous three years to identify if any information was still relevant today that the Department may find informative. This is provided in the section part of this section.

Arizona

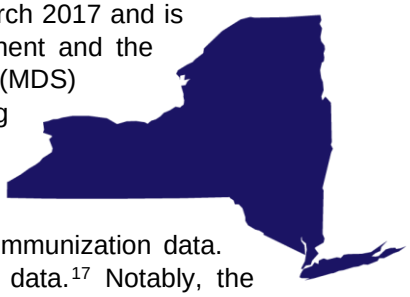
The Arizona Health Care Cost Containment System (AHCCCS) has implemented a VBP model to financially reward providers. These providers must meet or exceed specific benchmarks to receive payment. Benchmarks are focused on specified quality and cost measures.[14] Arizona's 2016 VBP initiative included five measures, two of which were considered utilization measures, and three that were considered clinical care quality measures. Specific goals included reducing the rate of readmission within 30-days to below 20% and also reducing emergency department utilization to below 20%. Arizona's 2018 VBP model includes two clinical care quality measurements that are that are focused on improving pneumococcal vaccination rates and influenza vaccination rates.[15] The 2018 VBP model will operate from October 1st, 2017 to September 30th, 2018. This model allows select AHCCCS-registered providers to meet the two clinical care quality measures to receive a VBP Differential Adjusted Payment. The purpose of these payments is to reward the providers that have proven their commitment to improving patient experiences, improving members' health, and reducing cost of care. These adjusted payments will represent an increase in the current fee-for-service rates.

Ohio

In May 2017, Ohio's State Plan Amendment (SPA) 17-004 was approved to provide enhanced payment rates for nursing facilities that provide services to ventilator-dependent individuals. The payment is based on a per-diem payment rate for ventilator-dependent individuals in nursing facilities that participate in the Ohio Department of Medicaid (ODM) nursing facility ventilator program. The per-diem rate equals 60% of the statewide average of the total per Medicaid day payment rate for long-term acute care hospital services for the prior calendar year. The enhanced payment may be reduced by a maximum of five percent if the nursing home's numbers of ventilator-associated pneumonia (VAP) episodes exceed the maximum number of VAP episodes determined by ODM for two consecutive quarters.[16] Ohio requires managed care plans to pay the fee for service (FFS) rate, which enables them to pass the enhance payment on to the providers.

[14] https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html
[15] http://www.integratedcareresourcecenter.com/PDFs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf
[16] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-004.pdf

New York



New York's Nursing Home Quality Initiative (NHQI) Methodology was updated in March 2017 and is comprised of three components: the Quality Component, the Compliance Component and the Efficiency Component. The Quality Component is calculated using Minimum Data Set (MDS) 3.0 data from the 2016 calendar year, NYS employee flu vaccination data and nursing home cost report data to determine the percentage of contracted and/or agency staff utilized and the rate of staffing hours per day. The Compliance Component comprises CMS' five-star quality rating for health inspections, timely submission of nursing home certified cost reports, and timely submission of employee influenza immunization data. Lastly, the Efficiency Component stems from potentially avoidable hospitalization data.[17] Notably, the recently enacted State Fiscal Year (SFY) 18-19 budget included new initiatives that will impact New York's nursing homes. The Department of Health will reduce Medicaid revenue to a residential health care facility in a payment year by two percent to the lowest performing Nursing Homes. The two percent reduction will apply if in each of the most recent payment years, the facility was ranked in the lowest two quintiles of facilities based on NHQI performance and was ranked in the lowest quintile in the most recent payment year. Since the legislation has just been enacted, no Medicaid revenue reductions have been applied.

SUMMARY OF PREVIOUS INFORMATION COLLECTED

The 2016 Colorado P4P Recommendations Report also includes details on payment structures implemented in other states. Brief summaries for Indiana, Kansas and Minnesota's programs are provided below.

Indiana

Indiana's VBP program for nursing homes has a maximum per diem add-on of $14.30 as of 2011. This maximum add on amount accounts for as much as 12 percent of the Medicaid daily rate for the nursing homes who can obtain the add on. Scores to obtain a per diem add on are based on survey inspections, staffing, and quality of life measures. Indiana continues to improve and implement new scoring systems and formulas, which requires discussion and negotiations between the Indiana Division of Aging Office of Medicaid Policy and Planning and representatives of the nursing home industry. As of July 2013, the add-on formula is as such:

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

Kansas

The P4P Program in Kansas provides nursing homes with the opportunity to earn up to $9.50 per diem add per day. The program has two distinct per diem add on measure sets. There is the Quality and Efficiency Incentive Factor, which includes quality of care performance measures. This incentive factor is determined by three outcomes: case mix adjusted nurse staffing ratio, staff turnover and Medicaid occupancy. The per diem add on opportunity for this incentive is up to $5.50.

Then there is the PEAK 2.0 Incentive Factor, which includes measures related to person-centered care. For the PEAK Incentive, there are six levels that a home may fall within in adopting person-centered care. Each level is tied to a per diem amount, ranging from $0.50 - $4.00. According, the per diem add on for the PEAK Incentive can be as much as $4.00.

Minnesota

There are two nursing home incentive based payment programs in Minnesota. The Performance-based Incentive Program and the Quality Improvement Incentive Payment Program. The former rewards quality improvement through a competitive program that provides an increase in rates of up to 5 percent for up to three years. The

[17] https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/docs/methodology.pdf

nursing homes assume 20 percent of risk for outcomes on projects they initiate, thus they are guaranteed 80 percent of the state funding. The Quality Improvement Incentive Program allows nursing homes to choose areas of focus in any quality indicator or quality of life domain. The homes then set improvement goals by one standard deviation over the course of the review year and also must be in at least the 25th percentile. Financial incentives may be as much as $3.50 per resident day. It should be noted that nursing homes generally do not completely meet their goal thus receive a prorated per diem. This has ensured that the maximum allowable per diem of $1.75 in the state's funding is not exceeded.

Recommendation 12: The P4P program like more recently implemented VBP programs rewards quality. As more emphasis continues to be placed on outcomes, the Department may consider finding funding opportunities to enhance payments to homes who are in the highest quintile for quality measures the state is focused on improving.

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 three most recent 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 the four most recent quarters of data available for 16 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.

Table 3, below, displays each applicant's CMS Overall 5-star rating and Quality 5-star rating compared to their P4P application reviewer score and per-diem amount. In terms of Overall 5-star rating, out of the 130 applications received, 1 (1%) had a 0-star rating, 3 (2%) had a 1-star rating, 25 (19%) had a 2-star rating, 21 (16%) had a 3-star rating, 34 (26%) had a 4-star rating, and 46 (35%) had a 5-star rating. In terms of the Quality 5-star ratings: 1 (1%) had a 0-star rating, none had a 1-star rating, 4 (3%) had a 2-star rating, 26 (12%) had a 3-star rating, 26 (20%) had a 4-star rating, and 83 (64%) had a 5-star rating. It can be determined that a 1 or 2-star Overall rating did not deter facilities from applying for the 2018 Pay-for-Performance program, but having a 1 or 2-star Quality rating may have impacted participation.

Looking at average reviewer scores and (range) across the Overall star ratings the average final application score for 1-star facilities is 41 (range: 36-45), 2-star facilities is 59.2 (range: 19-87), 3-star facilities is 62.4 (range: 24-85), 4-star facilities is 64.4 (range: 0-94), and 5-star facilities is 60.9 (range: 12-94). Based on this analysis, CMS Overall 5-star rating is not necessarily a useful predictive indicator of success on the P4P application. While it is clear that the 3, 4, and 5-star facilities outperform the 0, 1, and 2-star facilities, there is not an upward linear trend in average score as star rating increases.

Furthermore, looking at average final scores and (range) across the Quality star ratings the average final application score for 2-star facilities is 71.8 (range: 70-74), 3-star facilities is 52.8 (range: 6-82), 4-star facilities is 64.5 (range:

24-94) and 5-star facilities is 61.4 (range: 0-94). Based on this analysis, Quality 5-star rating is not necessarily a useful predictive indicator of success on the P4P application.

Table 3. CMS 5-Star Rating Data with 2018 P4P Scores

Facility Name	2018 Final Review Score	Per-Diem Amount	CMS 5-Star Quality Rating	CMS 5-Star Rating
River Valley Inn Nursing Home	41	$1.00	0	0
Boulder Manor	36	$1.00	3	1
Devonshire Acres	42	$1.00	4	1
Fort Collins Health Care Center	45	$1.00	3	1
Aspen Living Center	63	$3.00	4	2
Bear Creek Center	68	$3.00	5	2
Berthoud Living Center	62	$3.00	5	2
Beth Israel at Shalom Park	87	$4.00	5	2
Castle Rock Care Center	19	$1.00	5	2
Cedarwood Health Care Center	60	$2.00	4	2
Colonial Columns Nursing Center	63	$3.00	5	2
Elms Haven Center	62	$3.00	4	2
La Villa Grande Care Center	46	$2.00	5	2
Minnequa Medicenter	61	$3.00	5	2
Palisades Living Center	48	$2.00	5	2
Parkmoor Village Healthcare Center	73	$3.00	4	2
Rehabilitation and Nursing Center of the Rockies	42	$1.00	5	2
Rehabilitation Center at Sandalwood	82	$4.00	5	2
Rock Canyon Respiratory and Rehabilitation Center	87	$4.00	5	2
San Juan Living Center	46	$2.00	5	2
Terrace Gardens Health Care Center	60	$2.00	3	2
The Gardens	20	$1.00	3	2
The Green House Homes at Mirasol	71	$3.00	5	2
The Pavillion at Villa Pueblo	20	$1.00	5	2
The Peaks Care Center	57	$2.00	5	2
The Valley Inn	81	$4.00	4	2
The Villas at Sunny Acres	44	$1.00	5	2
Valley View Health Care Center Inc.	75	$3.00	4	2
Windsor Health Care Center	83	$4.00	5	2
Colorado Lutheran Home	64	$3.00	4	3
Colorado Veterans Community Living Center at Homelake	24	$1.00	4	3
Casey's Pond Senior Living LTC	63	$3.00	4	3
Cedars Healthcare Center	72	$3.00	3	3
Centennial Health Care Center	85	$4.00	4	3
Christopher House Rehabilitation and Care Community	83	$4.00	5	3

Table 3. CMS 5-Star Rating Data with 2018 P4P Scores				
Facility Name	2018 Final Review Score	Per-Diem Amount	CMS 5-Star Quality Rating	CMS 5-Star Rating
Colorow Care Center	82	$4.00	3	3
Eben Ezer Lutheran Care Center	70	$3.00	2	3
Four Corners Health Care Center	72	$3.00	5	3
Hallmark Nursing Center	39	$1.00	5	3
Harmony Pointe Nursing Center	49	$2.00	5	3
Health Center at Franklin Park	53	$2.00	4	3
Juniper Village- The Spearly Center	58	$2.00	5	3
Kenton Manor	71	$3.00	5	3
Mountain Vista Health Center	30	$1.00	4	3
Pueblo Center	47	$2.00	3	3
Rio Grande Inn	74	$3.00	2	3
Riverwalk Post Acute and Rehabilitation	80	$4.00	4	3
Sundance Skilled Nursing and Rehabilitation	44	$1.00	5	3
Trinidad Inn Nursing Home	72	$3.00	3	3
Avamere Transitional Care and Rehabilitation-Brighton	78	$3.00	5	3
Allison Care Center	87	$4.00	5	4
Autumn Heights Health Care Center	67	$3.00	3	4
Avamere Transitional Care and Rehabilitation-Malley	73	$3.00	4	4
Brookshire House Rehabilitation and Care Community	77	$3.00	5	4
Cambridge Care Center	74	$3.00	4	4
Cheyenne Mountain Center	72	$3.00	2	4
Christian Living Communities Suites at Someren Glen Care Center	82	$4.00	5	4
Cottonwood Care Center	62	$3.00	5	4
Denver North Care Center	93	$4.00	5	4
Forest Street Compassionate Care Center	55	$2.00	4	4
Good Samaritan Society - Fort Collins Village	47	$2.00	3	4
Good Samaritan Society- Bonell Community	81	$4.00	4	4
Good Samaritan Society- Loveland Village	47	$2.00	4	4
Grace Manor Care Center	52	$2.00	5	4
Highline Rehabilitation and Care Community	80	$4.00	4	4
Hillcrest Care Center	37	$1.00	3	4
Holly Nursing Care Center	90	$4.00	5	4
Horizons Care Center	64	$3.00	3	4
Laurel Manor Care Center	65	$3.00	3	4
Lemay Avenue Health and Rehabilitation Facility	56	$2.00	5	4
Life Care Center of Westminster	6	$1.00	3	4
Littleton Care and Rehabilitation Center	0	$0.00	5	4

Table 3. CMS 5-Star Rating Data with 2018 P4P Scores				
Facility Name	2018 Final Review Score	Per-Diem Amount	CMS 5-Star Quality Rating	CMS 5-Star Rating
Mesa Manor Center	72	$3.00	5	4
Monte Vista Estates LLC	63	$3.00	3	4
North Star Rehabilitation and Care Community	94	$4.00	4	4
Park Forest Care Center, Inc.	67	$3.00	5	4
Parkview Care Center	79	$3.00	5	4
Sandrock Ridge Care and Rehab	52	$2.00	5	4
Sierra Rehabilitation and Care Community	92	$4.00	4	4
Southeast Colorado Hospital LTC Center	57	$2.00	5	4
Sunny Vista Living Center	74	$3.00	4	4
Sunset Manor	65	$3.00	5	4
Valley Manor Care Center	45	$1.00	5	4
Wheatridge Manor Care Center	62	$3.00	3	4
Spring Village Care Center	63	$3.00	5	5
Amberwood Court Rehabilitation and Care Community	74	$3.00	5	5
Arvada Care and Rehabilitation Center	49	$2.00	5	5
Aspen Center	50	$2.00	5	5
Bent County Healthcare Center	90	$4.00	5	5
Berkley Manor Care Center	18	$1.00	5	5
Briarwood Health Care Center	80	$4.00	5	5
Brookside Inn	84	$4.00	5	5
Broomfield Skilled Nursing and Rehabilitation Center	67	$3.00	5	5
Bruce McCandless CO State Veterans Nursing Home	71	$3.00	2	5
Centura Health- Namaste Alzheimer Center	26	$1.00	4	5
Cherry Creek Nursing Center	84	$4.00	5	5
Clear Creek Care Center	84	$4.00	5	5
Columbine West Health and Rehab Facility	66	$3.00	4	5
Cottonwood Inn Rehabilitation and Extended Care Center	46	$2.00	5	5
E Dene Moore Care Center	87	$4.00	5	5
Eagle Ridge of Grand Valley	89	$4.00	5	5
Englewood Post Acute and Rehabilitation	31	$1.00	5	5
Fairacres Manor, Inc.	73	$3.00	5	5
Garden Terrace Alzheimer's Center of Excellence	18	$1.00	5	5
Golden Peaks Center	83	$4.00	5	5
Hildebrand Care Center	60	$2.00	5	5
Holly Heights Care Center	94	$4.00	5	5
Jewell Care Center of Denver	70	$3.00	5	5
Julia Temple Healthcare Center	76	$3.00	5	5

Table 3. CMS 5-Star Rating Data with 2018 P4P Scores				
Facility Name	2018 Final Review Score	Per-Diem Amount	CMS 5-Star Quality Rating	CMS 5-Star Rating
Larchwood Inns	61	$3.00	5	5
Life Care Center of Littleton	42	$1.00	5	5
Life Care Center of Longmont	12	$1.00	5	5
Manorcare Health Services- Boulder	76	$3.00	5	5
Mantey Heights Rehabilitation and Care Center	36	$1.00	5	5
Mesa Vista of Boulder	79	$3.00	5	5
North Shore Health and Rehab Facility	48	$2.00	5	5
Pikes Peak Center	66	$3.00	5	5
Pine Ridge Extended Care Center	61	$3.00	4	5
Rowan Community, Inc	61	$3.00	5	5
Skyline Ridge Nursing and Rehabilitation Center	51	$2.00	5	5
Spanish Peaks Veterans Community Living Center	55	$2.00	5	5
St Paul Health Center	76	$3.00	5	5
Summit Rehabilitation and Care Community	65	$3.00	5	5
Valley View Villa	30	$1.00	5	5
Villa Manor Care Center	42	$1.00	5	5
Vista Grande Inn	80	$4.00	5	5
Walsh Healthcare Center	85	$4.00	5	5
Western Hills Health Care Center	46	$2.00	5	5
Westlake Care Community	73	$3.00	5	5
Willow Tree Care Center	24	$1.00	5	5

7. RECOMMENDATIONS

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

Recommendation 1: *Clarify language so both applicants and reviewers have the same expectations of what is acceptable as supporting documentation. For example, "based upon the facility assessment" could be more instructive if re-worded to state "describe information from the facility assessment and how it applies to [X measure]".*

Recommendation 2: *Keep minimum requirements language consistent if they are requesting the same type of supporting documentation. All minimum requirements related to testimonials should be required to be "signed" or "unsigned". Furthermore, provide a clear definition of what qualifies as an acceptable testimonial.*

Recommendation 3: *Identify minimum requirements within measures that request essentially identical or interchangeable supporting documentation. Applicants either upload more documents than necessary or upload the supporting documentation for only one of the minimum requirements, which the reviewer may see as insufficient for meeting both minimum requirements.*

Recommendation 4: *One piece of supporting documentation should not impact multiple measures as an applicant who has an issue with this one document can lose a significant amount of points. Reconsider the weight the Nationally Reported Quality Measures Scores Narrative has on earning points for the eight Quality Measures.*

Recommendation 5: *Continue to monitor user experience with the application web portal to identify common issues experienced by the nursing home facilities and reviewers. Enhancements to the web portal can lessen administrative burden and streamline the application and review process.*

Recommendation 6: *Consider adding a review timeline message into the automated submission email that the system currently sends when a facility submits an application. This message would highlight the preliminary review, the results notification letters, and appeals period. A brief description of each phase of the review and their associated timeline would be included in this automated message which would lead applicants to have a better understanding of review processes and expectations.*

Recommendation 7: *Reach out to nursing homes that have created an account on the web portal but did not submit an application in the 2018 P4P program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.*

Recommendation 8: *Create a dedicated email for the P4P program. Application inquiries and technical issues can all be routed to this email. Any emails that currently go to the Department can continue to do so, including appeals and specific program questions.*

Recommendation 9: *As preventable hospital readmissions are the primary focus in SNF VBP we suggest reevaluating how hospitalizations are currently scored in the Colorado P4P program. One consideration is to include a year to year improvement threshold for facilities who have hospitalization rates below the national average but can still qualify for points as opposed to receiving points for any improvement**.***

Recommendation 10: *Continue to develop measures within the P4P tool that do not require additional or redundant reporting from facilities for data. Instead, build measures where facility-level data can be obtained and calculated by the Department from validated sources like CMS.*

Recommendation 11: *Explore dedicating funds for rewarding nursing homes who show an improvement in their application scores. This would be a modification of California's structured payment program. Specific to Colorado, the Department could potentially provide a financial incentive for homes who score 0-20 points, thus not meeting the threshold to receive any per diem add on. These homes may be discouraged from submitting an application. Some amount of financial incentive to encourage the home to continue building its program to meet P4P measures may increase program participation in future years.*

Recommendation 12: *The P4P program like recently implemented VBP programs rewards quality. As more emphasis continues to be placed on outcomes, the Department may consider finding funding opportunities to enhance payments to homes who are in the highest quintile for quality measures the state is focused on improving.*

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