Colorado Department of Health Care Policy and Financing

2019 Nursing Facilities Pay for Performance Application Review

Recommendations Report

June 26, 2019

PCG Health

Public Focus. Proven Results.™

TABLE OF CONTENTS

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 2019 (calendar year 2018) Pay for Performance (P4P) program. This Recommendations Report is supplemental to the 2019 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

Since its implementation in 2019, the Colorado P4P Program has continuously evolved to ensure that nursing facilities consistently strive to provide high quality care to its residents. Overall, the Department has implemented changes to the application and submission process with the aim of improving clarity, increasing participation, easing administrative burden and encouraging nursing facilities to improve on key quality measures in Colorado. Revisions to the 2019 application included improvements in measures, minimum requirements, and scoring from the previous application period.

To encourage program participation and aid the provider submission process, PCG developed a web portal which was used by nursing facilities to complete and submit applications. The 2019 application cycle marked the third year a web portal was used to collect provider submissions, and the experiences and feedback from the previous year were used as opportunities to enhance the web portal application to improve user experience from both the applicant and reviewer perspective.

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

Significant progress has been made to reduce the ambiguity of minimum requirement language. While impossible to eliminate, the 2019 application cycle saw fewer appeals for requirement interpretation. The most common was around *Measure 8.2: Physical Environment—Noise Management*. It was found that facilities often had questions regarding what to do if alarms were not used, and what alarms should be tracked. The inclusion of language specifying facilities to track all audible alarms such as bed, door, chair, and wander guard and to write N/A for categories which were not applicable helps ensure the facility submits an accurate application and that the reviewer understands what specific criteria to look for.

Recommendation 1: Clarify that all audible alarms should be tracked and how a facility should indicate that an alarm type may not be applicable to them.

Another common misinterpretation was for *Measure 13: Transitions of Care*, regarding the name and contact designated to act as a community liaison. Adding clarifying language that the department would like the name and contact of an external transition resource will help reduce the miscommunication on this requirement.

Recommendation 2: Clarify language that the minimum requirement is for the name and contact of an individual at the local agency who serves as the liaison between the facility and agency for community placements.

Lastly, PCG recommends additional clarification around *Measures 16.2-16.9*. The 2019 application attempted to add further clarity by specifying that the CASPER facility adjusted percentage should be used; However, there were still multiple facilities who entered the raw percentage. Publicizing to facilities at the fall conference and trainings which percentage to use can reduce the discrepancy between facility and reviewer scores. Furthermore, some CASPER measures have similar names when abbreviated in the report. This led to the usage of incorrect quality measure scores in some of the calculations. Specifying the measure ID number in the application tool in addition to the quality measure title could improve clarity in this area.

Recommendation 3: Publicize during the fall conference and at trainings that the facility adjusted percentage from CASPER reports should be used to improve accuracy during the application and review process.

Recommendation 4: Display the quality measure ID along with quality measure title in the portal tool to improve accuracy during the application and review process.

Supporting Documentation & Administrative Burden

Feedback from nursing home staff during the on-site reviews included words of appreciation that the application was less burdensome since transitioning to the online portal. However, one measurement facilities provided feedback on was *Measure 14: Continuing Education*. Facilities noted that it was laborious to track and prove hours of training for staff. Due to new statutory requirements, the Department will be deleting this measure beginning with the 2020 application, eliminating this issue.

2.2 Application Process

Web Portal

As mentioned previously, this was the third 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. It was noted from the 2018 application that facilities forgot to upload a copy of their facility survey once leaving the prerequisite page. A section was added on the completion summary to indicate whether the survey was uploaded for the section or not. There were multiple enhancements to saving a facility's progress through the portal, including a feature where users were able to save their progress on a page regardless of whether it was fully completed. The 2019 portal application also featured automatic saving when navigating through the portal (e.g. the previous, summary, and next navigation). This reduces the likelihood a facility loses their inputted information.

Further system development can be considered to streamline the application and review process. The following improvements can be made to enhance the current application:

- 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.
- Requiring tool competition in the portal instead of allowing for equivalent documentation uploads. Documents that are uploaded do not have their data easily accessible for analysis.
    - Add an upload from Excel capability to streamline data collection and upload.
- The tool in *Measure 19: Staff Retention Improvement* will not save unless both percentages for staff retention rate and retention improvement are entered. It is recommended that this feature is revised as the measure only requires one or the other for points.
- Clarifying the maximum file size accepted by the portal.

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.

The last day of application submission had upload issues. The server ran out of storage space, not allowing users to upload their supporting documentation. This resulted in a steady stream of calls and emails about this issue. While the issue was resolved by midday, it did create an inconvenience for facilities. Hard drive storage should be upgraded or cleared prior to the final week of the submission deadline to ensure these issues do not occur.

Recommendation 6: Ensure enough portal hard drive storage prior to final submission deadline. This can be accomplished by clearing unnecessary materials or upgrading storage space.

There were several facilities who submitted appeals stating that they had the documentation, but it was not uploaded. The preliminary review process (discussed in the next section) allows detection of some of these issues, but it remains the facility's responsibility to verify all required documents are attached at submission. To make this process easier, adding a feature displaying the total number of documents uploaded may provide a quick way for facilities to check whether all their files were attached.

Recommendation 7: Add under the "File Upload" window a count for the total number of files uploaded. This can be at the bottom of the list of files. It can help facilities quickly check whether all of their documentation was successfully uploaded into the portal and address the multiple comments received in prior applications.

This year, a dedicated P4P email and toll-free number was set up to respond to questions. However, not all facilities were aware of this direct line of contact. If providers went to the portal before logging in and clicked the "Contact Us" tab, they were led to a form that went to PCG's general corporate contact us form, which is then forwarded to the appropriate team. This resulted in a delay for responses. For future years, the "Contact Us" tab should reference to a page with the direct email and phone number for quicker communication with facilities.

Recommendation 8: Change "Contact Us" page linked from the P4P portal login page with direct email and phone numbers created for the P4P program to ensure timely responses.

Preliminary Review Process

This year's review process included a preliminary application review which included identifying instances in which a home may have unintentionally failed to upload a document, or uploaded 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 timeline is tight to ensure adequate time for comprehensive reviews. Within a week after submission of applications, notifications are sent to facilities with a preliminary review finding. Facilities then have one week to upload the corrected documentation for measures specified in their preliminary review findings report. New documentation outside of what was requested is not allowed. The preliminary review, as indicated by its name, is not a comprehensive review and is only meant to catch clear instances of application oversight. It remains each nursing home's responsibility to review their application for completeness and accuracy prior to final submission.

Overall, the preliminary review found at least one finding for 43 facilities, thus giving nursing facilities the chance to resubmit their application with the appropriate documents and earn points that otherwise would have been lost. This was the second year a preliminary review was conducted. Most homes completed the process by having their application rolled back, uploaded the correct documentation, and resubmitted. However, some homes requested the rollback, uploaded the documentation, but did not resubmit. Facilities were asked to go back and recertify their application, but greater clarity on the need for resubmission can be given. Lastly, as the portal does not require a rollback to upload documentation, some homes were able to upload their documentation bypassing the rollback and submit process. Stopping uploading privileges after submission can ensure documentation is not uploaded past the due date unless for the official preliminary review process.

During the preliminary review process, some corrupted files were found. While the portal does not have an official mechanism for identifying corrupted files, this may be an area for exploration to improve the flow of the review process.

Recommendation 9: Emphasize the need for certification of applications at trainings. A number of facilities did not certify before the deadline or forgot to recertify after the preliminary review process. This helps reduce the need to track and contact facilities.

Recommendation 10: Disable file uploads after submission. Users are currently able to upload files whenever, including after submission. Without extra analysis or excessive attention from the reviewer, files improperly uploaded may be used for application score review.

Recommendation 11: Explore a review process to identify corrupted files within the preliminary review process. While not a significant problem, it does delay the review of some facilities.

2.3 Program Development and Participation

The number of P4P applicants has steadily increased through the years. In past years, 127-129 nursing facilities applied annually. In 2018, this number slightly increased to 130 applicants. For 2019, there were 138 total homes applying. The P4P web portal indicates that there are 196 nursing facilities with accounts to access the portal. There may be a number of reasons the 58 nursing facilities 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 facilities did not participate. This may be an opportunity for the Department to expand outreach and consider feedback that would encourage greater participation statewide.

Recommendation 12: Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2019 P4P program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.

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). CMS began 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), in fiscal year (FY) 2019. 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 rewards participating skilled nursing facilities based on measures associated with hospital readmissions.

Specifically, CMS measures:

- 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]

The risk-adjusted readmission rate is determined by calculating the standardized risk ratio, then using the standardized risk ratio to calculate a facility-level standardized readmission rate.[2] The standardized risk ratio is the dividend of the predicted number of readmissions and the expected number of readmissions if the same patients were treated at an average facility. The standardized risk ratio is then multiplied with the mean rate of readmission in the population to calculate the facility-level standardized readmission rate.

There are nuances for what is considered as a readmission. For the predicted number of readmissions, hospital readmissions that occur after discharge from the nursing facility, but within the 30-day proximal hospitalization are included. Readmissions identified as planned readmissions or observation stays are excluded. For the expected number of readmissions, stays where the patient has one or more intervening post-acute care admission within the 30-day window, had multiple nursing facility admissions within the 30-day window, or has a gap greater than 1 day between hospitalization discharge and nursing facility admission are excluded. Also excluded are nursing facility stays where the patient did not have at least 12 months of fee for service Part A Medicare enrollment before the hospitalization discharge, where the patient was discharged from the skilled nursing facility against medical advice, or if the principal diagnosis of hospitalization was for cancer, rehabilitation care such as fitting of prostheses and adjustment of devices, or pregnancy. Nursing facility stays where the data is missing or problematic with respect to variables used for rate calculation can also be excluded.

CMS provided a fact sheet[3] 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 to 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

[1] https://www.cms.gov/Medicare/ Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
[2] https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=521
[3] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/Top-10-things-to-know-about-SNFRM.pdf

- CMS will propose to replace the SNFRM with the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR) in future rulemaking."

All SNFs 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 are funded by a two percent reduction in the adjusted Federal per diem rate paid to SNFs for the FY. Sixty (60) percent of this withheld amount represents the total available funding for the incentive payments.[4] Nearly all Colorado P4P SNFs are participating in the SNF VBP.[5]

The FY2019 program evaluated CY17 (January 1-December 31, 2017) data using CY15 (January 1-December 31, 2015) as the baseline period. The FY2020 program will evaluate FY2018 (July 2017-June 2018) data using FY2016 (July 2016-June 2016) as the baseline. The FY2021 and FY2022 programs are also projected to use FY data. CMS utilizes the SNFRM to evaluate if there was any improvement between the evaluated FY and baseline FY. SNFs receive a score based on both their improvement and achievement between the baseline and performance year. CMS uses these scores to develop incentive multipliers. SNFs that earn higher scores receive higher incentive payments than lower performing peers. SNFs with performance scores that are ranked in the lowest 40 percent nationally receive payments at a rate lower than they would have without the SNF VBP.[6]

For the FY2019 program, the national average performance score was 34.5 points. Colorado facilities performed slightly above average with an average performance score of 45.2 points. Nearly a quarter of the facilities from Colorado fell within the national 40th percentile, receiving a lower payment rate than without the VBP program. The P4P application currently has a measure around reducing avoidable hospitalization; however, creating a measure to focus on hospital readmission improvement may initiate processes to increase qualification and reimbursement under the SNF VBP program.

Recommendation 13: ***Continue to monitor the performance of Colorado P4P facilities in the FY2019 SNF VBP.***

Recommendation 14: Since preventable hospital readmissions are the primary focus in SNF VBP, we suggest reevaluating how hospital readmissions are currently scored in the Colorado P4P program.

[4] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf
[5] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-Public-Reporting-Oct-2017.xlsx
[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 its 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 three P4P Recommendation Report that are still relevant and may be instructive for any program changes.

MINNESOTA

On January 1st, 2016, Minnesota Legislature authorized a new system for nursing facility reimbursement rates, which the Department of Human Services calls the value-based reimbursement system. Under the value based-system, DHS sets facility reimbursement rates based on the cost of providing care to residents. Although the new system ties a facility's rate to its costs, DHS will not reimburse the facility for unlimited costs; a facility's rate will only reflect its care-related costs up to a limit. If a facility's care-related costs are greater than its limit, the facility's rate would not reflect the portion of the costs more than the limit. As with previous systems, facilities' rates are case-mix adjusted—facilities receive higher rates to care for more-resource intensive patients.

Within the value-based reimbursement system, Minnesota has implemented payments and rewards for high quality nursing facilities. Currently, DHS and the legislature have attempted to improve and reward nursing facility quality using three main strategies. First, DHS encourages facilities to improve their quality of care by publishing the Minnesota Nursing Home Report Card system. Second, the new value-based reimbursement system sets a limit on a facility's care-related reimbursement rate, and this limit is tied to the facility's quality score. Third, DHS operates two incentive programs that reward facilities who undertake quality improvement projects with rate increases.

The Minnesota Nursing Home Report Card

The Minnesota nursing home report card provides patients quality profile data of the nursing facilities in Minnesota based on three separate data sources. The first is a survey of residents in every facility on the quality of the nursing home and is conducted by a private contractor. The second are state inspections by the Minnesota Department of Health and the third are quality indicators that DHS derives from the comprehensive assessments and inspections conducted by MDH. These assessments are then broken down into (8) different quality measures so that patients can use the scores provided to make accurate choices. These quality measures include:

- Resident Quality of Life
- Family Satisfaction
- Clinical Quarterly Indicators
- State Inspection Results
- Hours of Direct Care
- Staff Retention
- Use of Temporary Nursing Staff
- Proportion of Beds in Single Rooms

Quality in the Value-based Reimbursement System

The value-based reimbursement system, effective January 1, 2016, builds a quality component into the operating payment rate by placing limits on care-related rates using a facility's quality score. For example, a facility with a higher quality score is subject to higher limits. These quality scores are calculated using the department's nursing facility quality profiles and are measured on a scale between 0-100. Fifty points of the score are based on a facility's quality indicator score which are derived from the Minimum Data Set's comprehensive assessments conducted at the facility. Forty points of the score comes from the, "resident quality of life score" from the survey of the facility's residents. The last 10 points come from the facility's, "state inspection results score."

Incentive Programs: PIPP and QIIP

DHS administers two programs that offer facilities time-limited rate adjustments to implement projects that improve the quality and efficiency of care. The Nursing Home Performance-based Incentive Payment Program (PIPP) awards rate increases on a competitive basis and is available to a limited number of facilities each year. In contrast, the Quality Improvement Incentive Program (QIIP) is a broader program that is open to any facility reimbursed under Medical Assistance.

PIPP has been offered since July 1st, 2006 and has allowed facilities to apply for a time-limited rate increase in exchange for implementing a program designed to increase the quality of the facility. There is a competitive application process to see which facilities receive the funding as individual facilities or a collaboration of multiple facilities can apply. Facilities can request up to a 5 percent increase in their current payment rate. These facilities will receive the extra funding as long as they maintain projected program outcomes. Some of these programs DHS has provided funding for include improvement in employee recruitment and retention, reduce the rate of falls among residents, and improve residents dining experiences.

QIIP is a more recent incentive program authorized by the 2013 Legislature which went into effect on October 1st, 2015. In contrast to PIPP, this program eliminates the competition and allows all facilities to take part in a rate increase. To participate in the process, a facility only needs to select a single quality indicator and work to improve that measure. These quality measures are split up into 38 individual measures and a facility may pick from a list of 26 “quality indicators” or 12 “quality of life domain scores.” The rate increase is determined of the amount of improvement seen in the selected quality measure relative to the previous year. The goal is improve by one standard deviation which usually is equal to the percent of its goal achieved times $3.50.

TEXAS

Texas implemented the Quality Incentive Payment Program (QIPP) in September of 2017. QIPP was formed out of the Texas’s Minimum Payment Amounts Program, which began in 2015 to meet the Texas Legislature’s desire to transition nursing facilities to a managed care model. QIPP is authorized by the Health and Human Services Commission Budget Rider 97 in the 2016-2017 budget. It is a Medicaid managed care delivery system, utilizing STAR+PLUS MCOs. Reimbursement is based on the Medicare & Medicaid five-star rating system.

For the first 2 years, QIPP is paid through three components of nursing facility managed care per member per month capitation rates. The first component is for non-state government owned facilities. Facilities receive monthly payments determined by the nursing facility’s submission of a monthly Quality Assurance Performance Improvement Validation Report. Facilities are eligible for up to 110 percent of the non-federal share of the QIPP program.

The second and third components are available to all facilities by meeting national benchmarks or showing minimum or strong improvement, respectively, on the following measures:

- High-risk long-stay residents with pressure ulcers;
- Percent of residents who received an antipsychotic medication;
- Residents experiencing one or more falls with major injury; and
- Residents who were physically restrained.

Improvement is measured from a baseline value, determined for each facility as the average performance for the four quarters prior to the first day of the eligibility period. A minimum improvement is defined as a 1.7 percent improvement each quarter, adding to a 7 percent improvement by the end of the yearlong eligibility period. A strong improvement is defined as a 5 percent improvement from baseline quarterly, adding to a 20 percent improvement by the end of eligibility period. Component Two has 35 percent of remaining QIPP after accounting for Component One funding needs, while Component Three has the remaining 65 percent of funding. Payments are made quarterly if facilities are meeting the benchmarks. Each measure is worth an equal amount and in the event a facility does not have a score for the measure, the funding associated will be distributed to the remaining metrics.

Year three, beginning in September of 2019, will have significant changes. Component One will remain the same. The second and third components' funding is changed to 30 and 70 percent, respectively, after accounting for the funding of Component One and a newly added Component Four. The fourth component receives 16 percent of QIPP funds. Like Components Two and Three, funding will be distributed quarterly if facilities meet specific quality measures that are pending CMS approval. Component Four measures have not yet been published.

SUMMARY OF PREVIOUS INFORMATION COLLECTED ON OTHER STATES' PROGRAMS

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 can participate in the program. There are currently 290 actively participating facilities.[7] 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 quality measures meant to encompass three different areas of satisfaction: the resident, family, and employee.

Quality data is collected through multiple mechanisms. Quality of life data is collected through surveys 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. Family members also complete the survey, which is mailed to their homes. Quality of care is determined using 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.

GEORGIA

Georgia's Department of Community Health (DCH) decided to take part in Nursing Home Quality Improvement by implementing a P4P program. 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 facilities. Similar to OHCA, the DCH used nursing home performance information through My InnerView, a software and service for nursing facilities to monitor performance and quality measures, determine the quality incentive payments. My InnerView has research showing that state nursing facilities that take place in the statewide quality initiative achieve results, such as reducing resident falls, the use of physical restraints and antipsychotic medications, and reduction in staff turnover rates.

In 2007, 78 percent of facilities applying to the program received incentive payments.[8] In 2009, 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. [9]

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

[7] https://www.okhca.org/individuals.aspx?id=8135
[8] http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/52/28/80446139Press_Release-Nursing_Home_Quality_Initiative.pdf
[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

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.

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 facilities 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 facilities 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

[11] http://www.cahf.org/Portals/29/QCHF/2017/QASP%20DON.pdf?ver=2017-02-08-112725-853
[12] http://www.ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf
[13] http://health.utah.gov/medicaid/stplan/NursingHomes/QI/UHCA_April_2017_Presentation.pdf

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 percent from the state's general funds.

Recommendation 15: Explore dedicating funds for rewarding nursing facilities 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 applying. 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.

5. BEST PRACTICES

In our review of best practices this year, PCG focused on quality of care and quality of life. Like 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 and is provided in this section.

The Alabama Nursing Home Association conducts an annual showcase where homes around the state present best practices they developed to improve the quality of care or quality of life for residents. Related to quality of care, one home created an onsite dental program where a local dentist and hygienist provide services onsite.[14] The facility reported a reduction in risk of oral infection and risk of weight loss. They also reported a reduction in transportation costs and extra staff time required to transport residents. Residents do not pay out of pocket, rather, the facility uses Incurred Medical Expense billing to reduce the resident's financial liability to the facility. The facility then receives an increase in Medicaid dollars for the cost of the dental care, resulting the residents receiving dental care while the facility sees no impact to its revenue. Another best practice highlighted by the program was related to quality of life. A facility developed an activity to help individuals with dementia express themselves.[15] Twice a week, themed activity stations are set up with familiar music and activities, such as costume jewelry and blocks of wood. The facility notes that residents feel happier and useful.

Recommendation 16: Innovation is an important part of P4P programs. Setting up a similar sharing mechanism for Colorado facilities can provide new ideas to improve the quality of care and quality of life for their residents.

A recently published paper found that utilizing a smart watched-based communication system could improve call response times.[16] While this is a prototype study, the authors found a 40 percent reduction in response time to call lights to bedrooms, 58 percent reduction in response type to bathrooms, and a 29 percent reduction in response time to bed exit alarms. Further evaluation needs to be completed on efficacy and logistical barriers for implementation, but this is a novel idea that can improve the quality of care for patients.

Improving staffing ratios is another method of improving quality of care found in the literature.[17] There is a strong positive impact on outcomes with increased nursing staff. However, staffing levels should also consider acuity of residents. CMS does include acuity staffing their five-star rating methodology (discussed in the next section); however, a study notes that this methodology also underestimates needed staffing levels. Reviewing CMS's methodology, adjusting it to become more accurate, and rewarding facilities that meet or improve their staffing ratios may be a way to promote quality of care in Colorado.

SUMMARY OF PREVIOUS INFORMATION COLLECTED

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.[18] 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 percent and also reducing emergency department utilization to below 20 percent. 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.[19] The 2018 VBP model will operate from October 1st, 2017 to September 30th, 2018. This model allows select

[14] https://anha.org/uploads/web/Crowne-Mobile-BP-2017.pdf
[15] https://anha.org/communicating-with-people-unable-to-speak-2/
[16] https://www.ncbi.nlm.nih.gov/pubmed/31099184
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/
[18] https://www.azahcccs.gov/AHCCCS/Initiatives/PaymentModernization/valuebasedpurchasing.html
[19] http://www.integratedcareresourcecenter.com/PDFs/ICRC_VBP_in_Nursing_Facilities_November_2017.pdf

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 percent 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.[20] 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.

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.[21] Notably, the recently enacted State Fiscal Year (SFY) 18-19 budget included new initiatives that will impact New York's nursing facilities. 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.

INDIANA

Indiana's VBP program for nursing facilities 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 facilities 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 facilities 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.

[20] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OH/OH-17-004.pdf
[21] https://www.health.ny.gov/health_care/medicaid/redesign/nhqi/2017/docs/methodology.pdf

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. Accordingly, 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 nursing facilities 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 facilities 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 facilities generally do not completely meet their goal and 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 17: 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 facilities. 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 1, below, displays each applicant's CMS 5-star rating in additional to their P4P application self score and the final review score. Out of the 138 applications received, 0 (0%) had a 0-star rating, 16 (12%) had a 1-star rating, 27 (20%) had a 2-star rating, 23 (17%) had a 3-star rating, 32 (23%) had a 4-star rating, and 40 (29%) had a 5-star rating. It can be determined that a 1 or 2-star rating did not deter facilities from applying for the 2019 pay-for-performance program.

Furthermore, looking at average final scores and (range) across the star ratings the average final application score for 1-star facilities is 51.8 (range: 23-86), 2-star facilities is 61.4 (range: 32-89), 3-star facilities is 65.3 (range: 22-84), 4-star facilities is 67.7 (range: 26-93), and 5-star facilities is 72.8 (range: 37-98). Based on this analysis, CMS 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.

Table 1. CMS 5-Star Rating Data with 2019 P4P Scores			
Facility Name	**2019 Self Score**	**2019 Final Review Score**	**5-Star Rating**
Applewood Living Center	68	61	1
Berthoud Living Center	62	51	1
Boulder Manor	63	42	1
Elms Haven Center	62	62	1
Fort Collins Health Care Center	65	23	1
Glenwood Springs Health Care	29	29	1
Kenton Manor	68	62	1
Lakewood Villa	49	49	1
Minnequa Medicenter	83	75	1
Palisades Living Center	46	46	1
Pioneer Health Care Center	54	45	1
Rock Canyon Respiratory and Rehabilitation Center	95	86	1
Sierra Vista Health Care Center	68	59	1
Spring Creek Health Care Center	58	56	1
Sterling Living Center	43	36	1
Yuma Life Care Center	62	47	1
Alpine Living Center	74	49	2
Arborview Senior Community	87	87	2
Aspen Center	68	43	2
Autumn Heights Health Care Center	83	68	2
Avamere Transitional Care and Rehabilitation- Malley	90	89	2
Bear Creek Center	37	32	2
Cedarwood Health Care Center	70	57	2
Cherry Creek Nursing Center	84	61	2
Christopher House Rehabilitation and Care Community	63	44	2
Colorado Veterans Community Living Center at Homelake	33	33	2
Four Corners Health Care Center	84	72	2
Horizons Care Center	76	74	2
La Villa Grande Care Center	71	70	2
Mesa Manor Center	80	47	2
Monaco Parkway Health and Rehabilitation Center	55	48	2
Paonia Care and Rehabilitation Center	71	68	2
Park Forest Care Center, Inc.	73	67	2
Parkmoor Village Healthcare Center	72	73	2
Pearl Street Health and Rehabilitation Center	73	59	2
Pueblo Center	86	60	2
Rio Grande Inn	95	81	2
San Juan Living Center	71	62	2
Terrace Gardens Health Care Center	76	78	2

Table 1. CMS 5-Star Rating Data with 2019 P4P Scores			
Facility Name	**2019 Self Score**	**2019 Final Review Score**	**5-Star Rating**
Trinidad Inn Nursing Home	83	61	2
Valley Manor Care Center	65	60	2
Valley View Health Care Center Inc.	85	35	2
Windsor Health Care Center	81	79	2
Cambridge Care Center	83	72	3
Casey's Pond Senior Living LTC	85	83	3
Cedars Healthcare Center	86	84	3
Cheyenne Mountain Center	84	52	3
Colonial Columns Nursing Center	84	73	3
Colorado State Veterans Nursing Home- Rifle	78	72	3
Colorow Care Center	78	67	3
Devonshire Acres	69	61	3
Good Samaritan Society- Bonell Community	81	81	3
Grace Manor Care Center	79	74	3
Harmony Pointe Nursing Center	90	82	3
Holly Nursing Care Center	81	75	3
Juniper Village- The Spearly Center	78	75	3
Laurel Manor Care Center	76	76	3
Mantey Heights Rehabilitation and Care Center	63	57	3
Pikes Peak Center	75	68	3
River Valley Inn Nursing Home	34	28	3
Spanish Peaks Veterans Community Living Center	57	53	3
Sunset Manor	82	80	3
The Gardens	30	22	3
The Pavillion at Villa Pueblo	85	64	3
The Peaks Care Center	52	48	3
The Villas at Sunny Acres	80	56	3
Bent County Healthcare Center	93	93	4
Berkley Manor Care Center	52	49	4
Beth Israel at Shalom Park	91	90	4
Briarwood Health Care Center	73	63	4
Broomfield Skilled Nursing and Rehabilitation Center	70	62	4
Castle Peak Senior Life and Rehabilitation	71	31	4
Centennial Health Care Center	83	64	4
Eben Ezer Lutheran Care Center	86	84	4
Fairacres Manor, Inc.	87	85	4
Good Samaritan Society- Loveland Village	51	46	4
Highline Rehabilitation and Care Community	86	86	4
Jewell Care Center of Denver	89	84	4

Table 1. CMS 5-Star Rating Data with 2019 P4P Scores			
Facility Name	**2019 Self Score**	**2019 Final Review Score**	**5-Star Rating**
Julia Temple Healthcare Center	87	88	4
Littleton Care and Rehabilitation Center	55	55	4
Mesa Vista of Boulder	82	74	4
Mount St Francis Nursing Center	86	85	4
Mountain Vista Health Center	68	50	4
North Star Rehabilitation and Care Community	89	89	4
Parkview Care Center	92	83	4
Riverwalk Post Acute and Rehabilitation	95	55	4
Rowan Community, Inc	90	85	4
Sandrock Ridge Care and Rehab	68	68	4
Skyline Ridge Nursing and Rehabilitation Center	70	61	4
Southeast Colorado Hospital LTC Center	77	76	4
Spring Village Care Center	65	62	4
Suites at Clermont Park Care Center	78	61	4
Sunny Vista Living Center	84	74	4
The Green House Homes at Mirasol	82	79	4
Vista Grande Inn	80	65	4
Walsh Healthcare Center	87	49	4
Wheatridge Manor Care Center	76	43	4
Willow Tree Care Center	40	26	4
Allison Care Center	82	67	5
Amberwood Court Rehabilitation and Care Community	95	92	5
Arvada Care and Rehabilitation Center	89	74	5
Avamere Transitional Care and Rehabilitation- Brighton	95	85	5
Brookshire House Rehabilitation and Care Community	98	98	5
Brookside Inn	85	85	5
Bruce McCandless CO State Veterans Nursing Home	70	62	5
Centura Health- Medalion Health Center	66	47	5
Christian Living Communities Suites at Someren Glen Care Center	85	71	5
Clear Creek Care Center	82	80	5
Columbine West Health and Rehab Facility	74	66	5
Cottonwood Care Center	76	76	5
Cottonwood Inn Rehabilitation and Extended Care Center	77	77	5
Denver North Care Center	95	86	5
E Dene Moore Care Center	94	91	5
Eagle Ridge of Grand Valley	98	98	5
Englewood Post Acute and Rehabilitation	65	65	5
Forest Ridge Senior Living, LLC	75	57	5
Forest Street Compassionate Care Center	74	51	5

Table 1. CMS 5-Star Rating Data with 2019 P4P Scores			
Facility Name	**2019 Self Score**	**2019 Final Review Score**	**5-Star Rating**
Garden Terrace Alzheimer's Center of Excellence	37	37	5
Golden Peaks Center	92	90	5
Good Samaritan Society - Fort Collins Village	53	44	5
Health Center at Franklin Park	88	85	5
Holly Heights Care Center	89	90	5
Larchwood Inns	80	80	5
Lemay Avenue Health and Rehabilitation Facility	68	65	5
Life Care Center of Littleton	65	65	5
Manorcare Health Services- Boulder	81	81	5
North Shore Health and Rehab Facility	81	74	5
Pine Ridge Extended Care Center	69	54	5
Rehabilitation Center at Sandalwood	88	66	5
Sierra Rehabilitation and Care Community	87	87	5
St Paul Health Center	80	79	5
Summit Rehabilitation and Care Community	82	83	5
The Valley Inn	92	84	5
Uptown Health Care Center	61	50	5
Villa Manor Care Center	74	62	5
Washington County Nursing Home	64	54	5
Western Hills Health Care Center	78	67	5
Westlake Care Community	97	85	5

7. RECOMMENDATIONS

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

Recommendation 1: *Clarify that all audible alarms should be tracked and how a facility should indicate that an alarm type may not be applicable to them.*

Recommendation 2: *Clarify language that the minimum requirement is for the name and contact of an individual at the local agency who serves as the liaison between the facility and agency for community placements.*

Recommendation 3: *Publicize during the fall conference and at trainings that the facility adjusted percentage from CASPER reports should be used to improve accuracy during the application and review process.*

Recommendation 4: *Display the quality measure ID along with quality measure title in portal tool to improve accuracy during application and review process.*

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: *Ensure enough portal hard drive storage prior to last week. This can be accomplished by clearing unnecessary materials or upgrading storage space.*

Recommendation 7: *Add under the "File Upload" window a count for the total number of files uploaded. This can be at the bottom of the list of files. It can help facilities quickly check whether all of their documentation was successfully uploaded into the portal and address the multiple comments received in prior applications.*

Recommendation 8: *Change "Contact Us" page linked from the P4P portal login page with direct email and phone numbers created for the P4P program to ensure timely responses.*

Recommendation 9: *Emphasize the need for certification of applications at trainings. A number of facilities do not certify before the deadline or forget to recertify after the preliminary review process. This helps reduce the need to track and contact facilities.*

Recommendation 10: *Disable file uploads after submission. Users are currently able to upload files whenever, including after submission. Without extra analysis or excessive attention from the reviewer, files improperly uploaded may be used for application score review.*

Recommendation 11: *Explore a review process to identify corrupted files within the preliminary review process. While not a significant problem, it does delay the review of some facilities.*

Recommendation 12: *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2019 P4P program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.*

Recommendation 13: *Continue to monitor the performance of Colorado P4P facilities in the FY2019 SNF VBP.*

Recommendation 14: *Since preventable hospital readmissions are the primary focus in SNF VBP we suggest reevaluating how hospital readmissions are currently scored in the Colorado P4P program.*

Recommendation 15: *Explore dedicating funds for rewarding nursing facilities 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 applying. 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 16: *Innovation is an important part of P4P programs. Setting up a similar sharing mechanism for Colorado facilities can provide new ideas to improve the quality of care and quality of life for their residents.*

Recommendation 17: *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.*

The recommendations have also been sorted into categories to allow for more efficient discussion and task delegation. The categories are application recommendations, portal recommendations, and programmatic recommendations. The sorted recommendations can be found in Table 2.

Table 2. Recommendations by Category		
Application Recommendations	**Portal Recommendations**	**Programmatic Recommendations**
Recommendation 1: *Clarify that all audible alarms should be tracked and how a facility should indicate that an alarm type may not be applicable to them.* ***Recommendation 2:*** *Clarify language that the minimum requirement is for the name and contact of an individual at the local agency who serves as the liaison between the facility and agency for community placements.* ***Recommendation 3:*** *Publicize during the fall conference and at trainings that the facility adjusted percentage from CASPER reports should be used to improve accuracy during the application and review process.* **Recommendation 9:** *Emphasize the need for certification of applications at trainings. A number of facilities do not certify before the deadline or forget to recertify after the preliminary review process. This helps reduce the need to track and contact facilities.*	***Recommendation 4:*** *Display the quality measure ID along with quality measure title in portal tool to improve accuracy during application and review process.* ***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:*** *Ensure enough portal hard drive storage prior to last week. This can be accomplished by clearing unnecessary materials or upgrading storage space.* ***Recommendation 7:*** *Add under the "File Upload" window a count for the total number of files uploaded. This can be at the bottom of the list of files. It can help facilities quickly check whether all of their documentation was successfully uploaded into the portal and address the multiple comments received in prior applications.* ***Recommendation 8:*** *Change "Contact Us" page linked from the P4P portal login page with direct email and phone numbers created for the P4P program to ensure timely responses.* ***Recommendation 10:*** *Disable file uploads after submission. Users are currently able to upload files whenever, including after submission. Without extra analysis or excessive attention from the reviewer, files improperly uploaded may be used for application score review.*	**Recommendation 13:** *Continue to monitor the performance of Colorado P4P facilities in the FY2019 SNF VBP.* ***Recommendation 14:*** *Since preventable hospital readmissions are the primary focus in SNF VBP we suggest reevaluating how hospital readmissions are currently scored in the Colorado P4P program.* ***Recommendation 15:*** *Explore dedicating funds for rewarding nursing facilities 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 applying. 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 16:*** *Innovation is an important part of P4P programs. Setting up a similar sharing mechanism for Colorado facilities can provide new ideas to improve the quality of care and quality of life for their residents.*

Table 2. Recommendations by Category		
Application Recommendations	**Portal Recommendations**	**Programmatic Recommendations**
	Recommendation 11: *Explore a review process to identify corrupted files within the preliminary review process. While not a significant problem, it does delay the review of some facilities.* ***Recommendation 12:*** *Reach out to nursing facilities that have created an account on the web portal but did not submit an application in the 2019 P4P program. Engage these homes through a short survey and follow up as necessary to collect information around barriers to participation.*	***Recommendation 17:*** *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.*

www.publicconsultinggroup.com