Colorado Department of Health Care Policy and Financing

2024 Nursing Facilities Pay for Performance Application Review

Recommendations Report

June 2024

PUBLIC CONSULTING GROUP

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INTRODUCTION

Public Consulting Group LLC (PCG) was contracted by the Colorado Department of Health Care Policy and Financing (the Department) to review, evaluate, and validate nursing home applications for the 2024 (calendar year 2023) Pay for Performance (P4P) program. This Recommendations Report is supplemental to the 2024 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 creation and review process,
- Research into Centers for Medicare and Medicaid Services (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.

P4P PROGRAM REVIEW

Since its implementation in 2009, the Colorado P4P Program has continuously evolved to ensure that nursing homes consistently strive to provide high quality care to its residents. Each year, 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 2024 application included improvements in measures, minimum requirements, and scoring from the previous application period.

To promote program participation and aid the provider submission process, PCG developed a web portal which has been used by nursing facilities to complete and submit applications. The 2024 application cycle marked the eighth year that the PCG web portal was used to collect provider submissions. The experiences and feedback from the previous year informed enhancements to the web portal application, aimed at improving 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,
- Feedback collected from the Department/provider community on the application submission 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.

SUMMARY OF 2024 APPLICATION CHANGES

The following changes were made to the 2024 P4P program application.

Prerequisites

In 2024, the pre-requisite requirement changed to allow homes with substandard deficiencies, as defined in State Operations Manual, during the previous calendar year to be eligible to participate in the P4P program and receive half of their calculated payment. This was the only change to the 2024 Prerequisites section.

Quality of Life Domain

2023's Measure 9 (QAPI) has been removed. As a result, all 2024 measures after Measure 8 have shifted backwards in numbering by one.

Measure 9: Consistent Assignments

- The QAPI measure is being retired entirely. Measure 9 is now Consistent Assignments.
- It remains worth 4 points.

Measure 10: Volunteer Program

- Measure 10 is now Volunteer Program. It was previously Consistent Assignments.
- It remains worth 3 points.

Measure 11: Staff Engagement

- Measure 11 is now Staff Engagement. It was previously Volunteer Program.
- It remains worth 3 points.

Measure 12: Transitions of Care: Admissions, Transfer and Discharge Rights

- Measure 12 is now Transitions of Care: Admissions, Transfer and Discharge Rights. It was previously Staff Engagement.
- It remains worth 3 points.

Measure 13: Equity

- Measure 13 is now Equity. It was previously Transitions of Care: Admissions, Transfer and Discharge Rights.
- 4 points have been added to Measure 13, making it worth a combined total of 6 points.
    - Measure 13.1-1 through 13.1-3 (Initiatives) is now worth 4 points.
    - Measure 13.2-1 and 13.2-2 (Accessibility) is now worth 2 points.
- Measure 13's additions have been broken out into two subsections, Equity – Initiatives (13.1-1 through 13.1-3 and Equity – Accessibility (13.2-1 and 13.2-2).
- Minimum requirement 13.1-1 has been added. This requires submission of a home's written, public-facing statement from leadership that supports and prioritizes the implementation and/or administration of a program improving health disparities by ensuring equitable care is provided to all patients.
    - Also requires URL submission of home's public-facing statement.
- Minimum requirement 13.2-1 has been added. This requires submission of a narrative describing how a home ensures that communications with residents about their medical care in languages other than English meet non-English languages proficiency requirements.

    - This can include methods and services such as electronic translation services/language line/iPads, certified interpreters, and language proficiency assessments of staff who are communicating with patients regarding their medical care.
- Minimum requirement 13.2-2 has been added. This requires submission of a narrative around a home's plan for ensuring appropriate auxiliary aids and/or services are provided to individuals with a record of, or regarded as, living with a communications disability. Each of the below categories must be addressed:
    - Auxiliary aids/services for Individuals who are deaf or hard of hearing (ex: telecommunications devices (TDDs), interpretation services, assistive listening devices, television captioning and decoders, note-takers).
    - Auxiliary aids/services for Individuals living with speech deficits (ex: TDDs, computers, flashcards, alphabet boards, communication boards).
    - Auxiliary aids/services for Individuals living with vision impairments (ex: qualified readers, Brailled, taped, or large-printed materials).
    - Auxiliary aids/services for Individuals living with manual impairments (ex: TDDs, computers, flashcards, alphabet boards, communication boards).
    - Please describe a specific example of how this was done for one of your residents.

Measure 14: Isolation Protocols

- Measure 14 is now Isolation Protocols. It was previously Equity.
- It remains worth 2 points.

Quality of Care Domain

Measure 15: Vaccine Education

- Measure 15 is now Vaccine Education. It was previously Isolation Protocols.
- It remains worth 2 points.

Measure 16: Reducing Avoidable Hospitalizations

- Measure 16 is now Reducing Avoidable Hospitalizations (CMS, HCPF). It was previously Vaccine Education.
- It remains worth 3 points.

Measure 17: Nationally Reported Quality Measure Scores (CMS)

- Measure 17 is now Nationally Reported Quality Measure Scores (CMS). It was previously Reducing Avoidable Hospitalizations.
- This measure still requires, for minimum requirement 17.1-1, a narrative for a home's three highest percentile QMs. This narrative is worth 1 point.
- For minimum requirements 17.1-2 through 17.1-9, points are awarded based on a home's five highest-scoring QMs; 1-4 points are awarded for each of the selected percentile categories above the state median. The top 5 of 8 measures are utilized for scoring. These are collectively worth 20 total points.
- It remains worth 21 points total.

Measure 18: Best Practices

- Measure 18 is now Best Practices. It was previously Nationally Reported Quality Measure Scores (CMS).
- It remains worth 5 points.

Measure 19: Antibiotics Stewardship/Infection Prevention and Control (CMS)

- Measure 19 is now Antibiotics Stewardship/Infection Prevention and Control (CMS). It was previously Best Practices.
- The CDC published an updated version of the Infection Prevention and Control Assessment Tool. This measure now requires homes to complete and submit all sections pertaining to Long-Term Care Facilities in Sections 1 (Demographics – Long Term Care) and Modules 1 through 10 of the CDC Infection Control Assessment and Response Tool.
    - https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.thml
    - It remains worth 5 points.

Measure 20: Medicaid Occupancy Average

- Measure 20 is now Medicaid Occupancy Average. It was previously Antibiotics Stewardship/Infection Prevention and Control (CMS).
- It remains worth 4 points.

Measure 21: Staff Retention Rate

- Measure 21 is now Staff Retention Rate. It was previously Medicaid Occupancy Average.
- It remains worth 3 points.

Measure 22: DON and NHA

- Measure 22 is now DON and NHA. It was previously Staff Retention Rate.
- It remains worth 2 points.

Measure 23: Nursing Staff Turnover Rate (CMS)

- Measure 23 is now Nursing Staff Turnover Rate (CMS). It was previously DON and NHA.
- It remains worth 3 points.

Measure 24: Behavioral Health Care

- Measure 24 is Behavioral Health Care. It was previously Nursing Staff Turnover Rate.
- It remains worth 1 point.

SUMMARY OF 2025 APPLICATION CHANGES

The P4P Committee met between September 2023 – May 2024 to discuss adjustments for the 2025 P4P application. The below section describes the committee-approved changes for the upcoming P4P application.

Prerequisites

In 2024, the pre-requisite requirement changed to allow homes with substandard deficiencies, as defined in State Operations Manual, during the previous calendar year to be eligible to participate in the P4P program and receive half of their calculated payment. This change remains in the 2025 Application.

Quality of Life Domain

Measure 6: Trauma-Informed Care

- Minimum requirement 6.4 has been replaced with a Tool component, the Trauma-Informed Care Tool, which continues to ask for trauma-informed care training details:
    - The Tool asks for the date(s) where training(s) took place, the number of nursing/direct care staff in attendance, as well as the total number of the nursing/direct care staff employed at the home at the time of the training(s).
    - Recommended trainings come from three suggested resources: Substance Abuse and Mental Health Services Administration SAMHSA, Alameda County, and the Center of Excellence for Nursing Facilities (COE-NF). Homes also have the option to utilize a training resource beyond the three suggested within the tool granted they provide an additional narrative containing the title of the training as well as the training's objectives.
    - "Nursing/Direct Care Staff" is defined to include the following positions: Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Registered Nurses (RNs), Restorative Nursing Assistants (RNAs), and Medical Directors. All staff included should be full-time or part-time.
- Appendix 4 has been added to the Appendices tab to guide homes through the process of averaging and summing attendance data in the event that they hold multiple trainings for Measure 6 and Measure 23 (Behavioral Health Care, formerly Measure 24) throughout the year.
- The "Training Attendance Template" tab found on the Excel version of the application has been added as a resource for homes to utilize to capture all required attendance data for training requirements found in Measure 6 and Measure 23. This tracker auto-calculates the information necessary for completing the Trauma-Informed Care Tool and the Behavioral Health Care Tool.
- Minimum requirement 6-5 has been revised to request evidence for the specific trainings that occurred in the home and specified in the Trauma-Informed Care Tool. It lists examples of qualifying submission materials, including but not limited to attendance sign-in sheets and training presentation slides.
- It remains worth 5 points.

Measure 11: Staff Engagement

- Minimum requirement 11.6 has been revised to include a Staff Satisfaction Survey Tool. To receive points, homes must complete the tool, in addition to providing documentation of at least a 70% response rate for your Staff Satisfaction Survey and the results for an "Overall Satisfaction" question.
- The Staff Satisfaction Survey Tool has been implemented to collect data on the number of staff contacted, number of staff responding, name of vendor, who administers the survey, and how the survey is administered.
- It remains worth 3 points.

Measure 12: Transitions of Care: Admissions, Transfer and Discharge Rights (CMS, HCPF)

- Minimum requirement 12.6 has been added to address the onboarding process for new residents within the home. To receive points, homes must provide a narrative describing their process for onboarding new residents and how this process prepares them for and supports their transition to a nursing home setting, minimizes re-traumatization, and addresses their psychosocial and socioemotional needs.
- Appendix 5 has been added to the appendices tab and contains additional resources for homes to utilize in order to meet the expectations outlined in the new minimum requirement 12.6.
- Minimum requirement 12.7 has been added to address the onboarding process' development within the homes. To receive points, homes must demonstrate through a narrative and supporting documentation that resident input is included in the development of onboarding procedures. It lists examples of qualifying submission materials, including but not limited to Resident Council meeting minutes and new resident survey results.
- The points for this measure have increased by 1 point since the 2024 application. It is now worth 4 points.

Quality of Care Domain

Measure 16: Reducing Avoidable Hospitalizations (CMS, HCPF)

- The measure description of Measure 16 has been revised to clarify that Trend Tracker and National Nursing Home Quality Improvement Campaign data do not need to be submitted by the home as the information will be collected by the department from AHCA. Data will be measured from the most recently available rolling twelve-month average as opposed to a set date range as had been used previously.
- Minimum requirement 16.1 has been updated to reflect the change in data retrieval specified in the measure description. The department will independently validate that the home's long stay hospitalization rate has remained below 12.1% for the most recently available rolling twelve-month average OR if the home has documented improvement in rates between the two most recently available 12-month measurement periods. If either of the above is true following AHCA data review, the home will meet this minimum requirement.
- Minimum requirement 16.2 has been removed entirely from the application.
- Minimum requirement 16.3 ("Select four (4) cases and show the documentation your community provided to the receiving hospital/facility as well as the reason documented in the medical record as to why the individual was hospitalized or discharged to the receiving facility. (INTERACT or like program paperwork is expected)") remains the same but is now numbered as minimum requirement 16.2 following the removal of the 2024 application's minimum requirement 16.2.
- Minimum requirement 16.4, which allowed homes the chance to receive a QAPI recovery point for this measure, has been removed entirely from the application.
- It remains worth 3 points.

Measure 17: Nationally Reported Quality Measures Scores (CMS)

- This measure will be updated with calculated percentiles from data reported on CMS's Care Compare website for all homes in Colorado for the specified QM in both Q3-2023 and Q4-2023.
- It still requires a narrative for a home's three highest percentile QMs, with points awarded on a home's five best scores.
- It remains worth 21 points*.
    - *1-4 points awarded for each of the selected percentile categories above the state median. The top 5 of 8 measures are utilized for scoring (20 total points available).

Measure 20: Staff Retention Rate

- 2024's Measure 20 (Medicaid Occupancy Average) has been removed. As a result, all 2025 measures after Measure 19 have shifted forward in numbering by one.
- Measure 20 is now Staff Retention Rate. It was previously Medicaid Occupancy Average.
- It remains worth 3 points.

Measure 21: DON and NHA Retention

- Measure 21 is now DON and NHA Retention. It was previously Staff Retention Rate.
- It remains worth 2 points.

Measure 22: DON and NHA Retention

- Measure 22 is now Nursing Staff Turnover Rate. It was previously DON and NHA Retention.
- It remains worth 3 points.

Measure 23: Behavioral Health Care

- Measure 23 is now Behavioral Health Care. It was previously Nursing Staff Turnover Rate.
- Minimum requirement 23.1 has been completely altered and the RAE contact information component removed entirely. Now, homes must complete a minimum of three specified trainings provided by the Center of Excellence for Nursing Facilities as specified in the newly added Behavioral Health Care Tool.
    - These trainings include the mandatory "Mental Health 101: Suicide Prevention and De-Escalation Strategies" and two of the remaining three optional trainings specified: Serious Mental Illness, Substance Abuse 101, and Addressing Co-Occurring Disorders in Nursing Facilities.
    - Each training must be attended by a minimum of two (2) champions per department listed within the tool. The tool will then require the training date(s), number of nursing/direct care staff in attendance, as well as the number of nursing/direct care staff at the home at the time of each training.
    - "Nursing/Direct Care Staff" is defined to include the following positions: Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Registered Nurses (RNs), Restorative Nursing Assistants (RNAs), and Medical Directors. All staff included should be full-time or part-time
- Appendix 4 has been added to the appendices tab to guide homes through the process of averaging and summing attendance data in the event that they hold multiple trainings for measures 6 and 23 throughout the year.
- The "Training Attendance Template" tab found on the application has been added as a tool for homes to utilize to capture all required attendance data for training requirements found in measures 6 and 23. This tracker auto-calculates the information necessary for completing the Trauma-Informed Care and Behavioral Health Care Tools.
- The points for this measure have increased by 3 points since the 2024 application. It is now worth 4 points.

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RECOMMENDATIONS FOR APPLICATION MEASURES

Minimum Requirements Specificity and Training

PCG has provided further recommendations for clarifying measure language and areas for specific training in future P4P applications.

***Recommendation 1*: More clearly delineate "evidence" in all relevant instances across measures.** Across multiple measures of the application, we require homes to provide actual evidence of their staff training, how they have involved residents in key processes, volunteer opportunities at the home, etc. Homes often still struggle with correctly satisfying these evidentiary requirements, regularly providing only a written narrative in lieu of proper evidence. As such, we recommend better defining "evidence" and the specific kind of documentation we are looking for when we request evidence. Specifically, in all instances where evidence is required, we recommend inserting into the measure language examples of good evidence (e.g., staff training attendance sign-in sheets dated and titled with the name of the relevant training) as a guide for homes.

***Recommendation 2:* Emphasize that correct testimonial dates are a requirement.**

PCG noted a number of instances across the 2024 Application cycle where resident and staff testimonials were dated out of the correct application year (i.e., a testimonial was dated "February 2024", but the testimonial was supposed to pertain to the time period between January 2023 – December 2023). We recorded 18 separate instances of a home losing points on a given measure due to having incorrect testimonial dates. As a result, we recommend clarifying in all relevant instances of measure language that testimonials must be dated within the appropriate application year. (i.e., for upcoming Application Year 2025, all submitted testimonials must be dated within 2024.) We recommend doing this specifically in both of the provider application changes trainings scheduled for the upcoming application year.

***Recommendation 3:* Streamline the language of Measure 8.2 (Physical Environment – Noise Management) by eliminating redundancy.**

We recommend reconfiguring the format of minimum requirements 8.2-1 and 8.2-2 to reduce redundancy and streamline measure language. Specifically, we recommend doing the following:

- Split the existing 8.2-1 into two separate minimum requirements. Currently, 8.2-1 requires both 1) evidence of an evaluation and action plan to coordinate patient care, operations and maintenance activities to reduce patient disruptions that involves residents, visitors and staff of the extraneous noise throughout the building and identify the various opportunities to reduce the noise, and 2) a plan/policy speaking to the reduction or elimination of extraneous noise such as bed, door and wheelchair alarms. Providers regularly will only address one of these two bullets in their response. The aim is to cut down on such provider error by better delineating the measure requirements of providing both evidence of such an evaluation and action plan and a noise plan/policy.
- Additionally, we recommend incorporating existing 8.2-2, which is "Include a description of strategies used to reduce the extraneous noise. If no improvement is noted, explain the difficulties experienced" into 8.2-1 to create a singular, cohesive minimum requirement.
- This new 8.2-1 would thus read as: *"Please provide evidence of an evaluation and action plan to coordinate patient care, operations and maintenance activities to reduce patient disruptions that involves residents, visitors and staff of the extraneous noise throughout the building and identify the various opportunities to reduce the noise. Please also be sure to include a description of strategies used to reduce the extraneous noise. If no improvement is noted, explain the difficulties experienced."*
- The new 8.2-2 would thus read as: *"Please provide a plan/policy speaking to the reduction or elimination of extraneous noise such as bed, door and wheelchair alarms."*

Recommendation 4: **Conduct a Quality Measure best practices overview and refresher.**

Measure 17, the Nationally Reported Quality Measures Scores (CMS) measure, consistently sees provider data entry error year over year. However, such error was exacerbated during the 2024 Application cycle. We believe a primary driving factor here was the change in quarters utilized; data for four QMs (High Risk Resident with Pressure Ulcers(L) N015.03, Low Risk Residents who Lose Control of Bowel/Bladder (L) N025.02, Residents Whose Need for Help w/ Daily Activities Has Increased (L) N028.02, and Residents Whose Ability to Move Independently Worsened (L) N035.03) was not available for Quarter 4 of 2023. Homes who had thus been accustomed to providing their relevant QM data for Quarters 3 and 4, and who failed to realize that they needed to provide Quarter 2 instead, consequently lost those points. As this QM freeze will be a likely recurrence this upcoming application year, we recommend emphasizing to homes the importance of a) correctly and thoroughly reading all measure instructions and b) following best practices when providing their QM data. We recommend the specific following best practices for homes to follow:

1. Reread measure instructions to ensure they are providing the correct quarter of data.
2. Double check the data entered into the QM Calculation Tools to ensure accuracy and uniformity with their CASPER reports.
3. Ensure that provided CASPER reports are in the correct version formats.

Recommendation 5: Clarify in the prerequisite measure language that to qualify, Family and Resident Satisfaction Surveys must contain, at minimum, one respondent contacted and one respondent reply.

One of the two key components of the application's prerequisite section is the submission of homes' Family and Resident Satisfaction Survey findings, a survey which they are required to conduct within the specified application year. In the 2024 Application cycle, one home's final inputs reflected "0 survey respondents responded" and "0 survey respondents contacted". Upon further investigation, PCG discovered that this home's survey had only been live for one month (December 2023) of the relevant application year, so they consequently had zero responses. To curtail provider confusion and thus eliminate such error moving forward, PCG recommends clarifying in the prerequisite measure language that to qualify for consideration, homes' Satisfaction Surveys must contain at minimum one respondent contacted and one response, respectively.

Recommendation 6: **Clarify the intentions and expectations of both the Equity Measure's Initiatives and Accessibility sections.**

Improving health equity across marginalized resident groups continues to be a critically important goal of the CO P4P program. Over the past three application cycles, the Department, PCG, and the P4P Committee have continued to brainstorm ways to measure equity within Colorado nursing homes, which resulted in the implementation of the Equity– "Initiatives" measure in the 2023 application. The 2024 application introduced a second Equity subsection, Equity – "Accessibility", which requests information on the homes' processes for communicating with its residents whose native languages are not English about their medical care, as well as their processes for providing the necessary aids and services to residents with visual, speech, auditory, and manual impairments.

There were a significant number of homes that did not properly understand the Equity measure intentions and expectations across both its Initiatives and Accessibility sections, and consequently lost those respective measure points. For example, when asked in minimum requirement 13.1-1 to provide the home's written, public-facing statement from leadership that supports and prioritizes the implementation and/or administration of a program improving health disparities by ensuring equitable care is provided to all patients, a number of homes provided only their organization's Equal Employment Opportunity policy or Non-Discrimination Statement. In an effort to clarify what we are looking for in this measure, we recommend doing the following:

- Initiatives: For minimum requirement 13.1-1, distinguish the difference between health equity and DEI/Equal Employment Opportunity-related policy. We recommend doing this specifically via the August and December provider application trainings, as this will afford a dynamic forum for homes to receive direct guidance from the Department and PCG.
- For minimum requirement 13.1-2, provide homes with examples of good evidence (e.g., staff health equity training attendance sign-in sheet appropriately dated and titled) as a guide.
- For minimum requirement 13.1-3, better define health equity initiatives and provide homes with examples (e.g., newsletters with informational health equity content, calendars of homes' upcoming health equity-related events, documentation of a monthly/quarterly ableism awareness meeting at the home, etc.).
- Accessibility: For minimum requirement 13.2-1, clarify measure language to delineate that narratives must provide specific details on the translation tools and non-English language proficiency assessments or certification requirements used in the home. Additionally, consider linking the official state or federal definition of "non-English language proficiency" directly in measure language so that homes may better benchmark.
- For minimum requirement 13.2-2, better define "manual impairments" and specify that even if a home does not currently have a resident falling into that impairment category, they still must provide their process for providing such aids and services.

The information, research, and data provided below is a summary of the health equity literature reviews PCG performed for the 2024 Application year. Additionally, Colorado's Hospital Quality Incentive Program (HQIP) currently has measures related to equity of patient care within hospitals. The table below provides a side-by-side comparison of HQIP equity measures and a potential P4P counterpart.

Table 1. HQIP and P4P Equity Measure Comparison

HQIP Measure	Potential Nursing Home P4P Recommendation
Does the hospital's system accurately document self-identified race, ethnicity, and primary language? How does your hospital ensure that patients understand why race, ethnicity, and language data are being collected?	Provide a narrative on your home's process for collecting and documenting self-identified race, ethnicity, and primary language. Include examples of how residents are informed on why race, ethnicity, and language data is being collected.
Does the hospital provide staff education and training on how to ask demographic intake questions for staff in all settings where someone is registering patients or adding demographic information to a patient's record?	Provide evidence of staff education and training on how to ask demographic intake questions.
Are race, ethnicity, and language data accessible in the electronic medical record?	Provide a census of race, ethnicities, and languages spoken by residents in your home.
Does the hospital evaluate non-English language proficiency (e.g. Spanish proficiency) for providers who communicate with patients in languages other than English?	***Existing measure (Equity, Measure 13.2-1).***
Does the hospital educate all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system?	***Existing measure (Equity, Measure 13.2-1).***

HQIP Measure	Potential Nursing Home P4P Recommendation
Does the hospital provide staff-wide education on: i. Racial and ethnic disparities and their root causes? ii. Best practices for shared decision making?	***Existing measure (Equity, Measure 13.1-2).***
Does the hospital ensure that providers and staff engage in best practices for shared decision making?	Provide three (3) examples of how staff engaged in best practices for shared decision making.
Does the hospital engage diverse populations within its community regarding issues of equity in quality and safety to inform the decisions made by quality and safety leadership teams?	Provide a narrative on how your home ensures your resident council and quality and safety leadership teams are reflective of the diversity in your home's resident and staff populations. Include at least 1 (one) example of a strategy used. Provide a narrative on how your home engages community advocacy organizations around care best practices for diverse patient populations.
Does the hospital provide staff-wide education on implicit bias?	***Existing measure (Equity, Measure 13.1-2).***
Does the hospital provide convenient access to health records without delay (paper or electronic), at minimal to no fee to the patient, in a clear and simple format that summarizes information most pertinent to patient care and wellness?	N/A
Does the hospital have a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect?	Describe your home's mechanisms for residents, families, and staff to report inequitable care and episodes of miscommunication or disrespect. Provide evidence of communication to residents, families, and staff about mechanisms to report inequitable care and episodes of miscommunication or disrespect.
Does the hospital ensure that providers and staff engage in best practices for shared decision making?	Describe how your home ensures staff engage in best practices for shared decision making.
Does the hospital have a process to ensure a timely and tailored response to each report of inequity or disrespect?	Provide your home's policies and procedures for investigating reports of inequitable care and episodes of miscommunication or disrespect.
Does the hospital have discharge navigation and coordination systems post discharge to ensure that patients have appropriate follow-up care and understand when it is necessary to return to their health care provider?	N/A
Does the hospital provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern?	N/A
Does the hospital provide discharge materials that meet patients' health literacy, language, and cultural needs?	Provide four (4) examples of discharge plans that meet resident's health literacy, language, and cultural needs.

HQIP Measure	Potential Nursing Home P4P Recommendation
Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning?	***Existing measure (Equity, Measure 13.1-3)***
Does the hospital have a process in place for the regular reporting and monitoring of metrics (process and/or outcome) stratified by race and ethnicity and disseminate the information internally to staff and leadership? This could take the form of a dashboard, regularly distributed reports or other reporting and monitoring tools.	Provide evidence that your home periodically reviews care outcomes of residents by race and ethnicity.
Does the hospital implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes?	If you are unable to qualify for points for Equity in Care based upon the above minimum requirements, but you have performed a QAPI project for Equity in Care, you are able to earn one (1) QAPI recovery point by submitting a narrative of the QAPI project that includes how Equity in Caret is addressed, the problem statement, baseline data, intended goals, tools/processes utilized, and final outcomes.
Does the hospital consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of morbidity and mortality, and other clinically important metrics?	N/A
Does the hospital have a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?	N/A

Additionally, PCG conducted literature reviews for exploration into how to measure equity outcomes in nursing homes.

Scott, Menard, Sun, Murmann, Ramzy, Rasaputra, Fleming, Orosz, Huynh, Welch, Cooper-Reed, and Tsu (2024) conducted a systematic review[1] of nursing home residents and the origins of resident health disparities. Specifically, the review synthesized published evidence using an existing framework on the origins of health disparities and determine care-related outcome disparities for residents of long-term care, comparing minoritized populations to the context-specific dominant population.

21 of 34 included studies demonstrated disparities in care outcomes for minoritized groups compared to majority groups. Thirty-one studies observed differences in individual-level characteristics (e.g. age, education, underlying conditions) upon entry to homes, with several outcome disparities (e.g. restraint use, number of medications) present at baseline and remaining or worsening over time. Significant gaps in evidence were identified, particularly an absence of literature on provider information and evidence on the

[1] Oxford Academic, "Building Evidence to Advance Health Equity: A Systematic Review on Care-Related Outcomes for Older, Minoritized Populations in Long-Term Care Homes"

experience of intersecting minority identities that contribute to care-related outcome disparities in long-term care.

The review found differences in minoritized populations' care-related outcomes. The findings provide guidance for future health equity policy and research—supporting diverse and intersectional capacity building in long-term care.

The National Committee for Quality Assurance in 2023 compiled four key criteria[2] for measuring equitable care:

1. Select indicators of social determinants of health.
2. Select a reference group (a "standard" comparison group independent of the data vs. the data informing the comparison group).
3. Select health care quality metrics. These could include composites (e.g., vaccination rates, quality measures, infant mortality rates).
4. Use benchmarks (e.g., compare results to national estimates).

The four approaches are similar in how they underscore key dimensions for measuring care and outcomes, lay a foundation for a diversified measurement landscape, and give state Medicaid programs options for how to evaluate health plan quality performance – which can help focus quality improvement initiatives to advance health equity.

Wong, Ponder, and Melix (2023)[3] conducted rigorous quantitative and qualitative analysis of racial COVID-19 disparities across nursing homes in the United States. The study investigated the characteristics associated with COVID-19 cases and deaths among residents in U.S. nursing homes from 2020 to 2021, with a focus on geospatial and racial inequalities.

The analysis reveals that majority Hispanic facilities have alarmingly high COVID-19 cases and deaths, suggesting that these facilities have the greatest need for policy improvements in staffing and financing to reduce racial inequalities in nursing home care. At the same time, the researchers also detect COVID-19 hot spots in rural areas with predominately white residents, indicating a need to rethink public messaging strategies in these areas. The top states with COVID-19 hot spots are Kentucky, Pennsylvania, Illinois, and Oklahoma. This research provides new insights into the socio-spatial contexts and inequities that contribute to the vulnerability of nursing home residents during a pandemic.

Shippee, Fabius, Fashaw-Walters, Ng, Akosionu, and Travers (2021)[4] examine the evidence on the significant racial and ethnic disparities in nursing home and home- and community-based services (HCBS) in relation to systemic racism, outline existing policies that may improve or exacerbate racial and ethnic disparities, and make policy recommendations for action.

Their study utilizes the following Health Disparities Framework to Racial and Ethnic Disparities in the US Long Term Services and Supports System:

- Environmental
    - Socioeconomic Factors
        - Personal and family income
        - Wealth
        - Education
        - Knowledge
        - Health literacy

[2] National Committee For Quality Assurance (NCQA), "New Analysis Sums Up How to Measure Health Equity"
[3] National Library of Medicine, "Spatial and Racial Covid-19 Disparities in U.S. Nursing Homes"
[4] The Journal of Post-Acute and Long-Term Care Medicine, "Evidence for Action: Addressing Systemic Racism Across Long-Term Services and Supports"

    - Geographic Factors
        - Neighborhood residential segregation
        - Area-level social disadvantage
        - Geographic variation in access to care
    - Health Care
        - Availability of services
        - Access to services
        - Type of insurance (Medicare, Medicare Advantage, Medicaid vs private pay)
        - Quality of care and quality of life
        - Government regulation and policies
- Sociocultural
    - Cultural Factors
        - Preferences for proximity of care
        - Preferences for facilities with similar racial composition
        - Preferences for care in nonresidential settings
    - Social Factors
        - English-language proficiency
        - Immigrant status
        - Systemic racism in long-term care
        - Systemic ageism
        - Family values and norms that impact care delivery
    - Psychological Factors
        - Cognition and cognitive decline
        - Resilience
        - Social isolation
- Behavioral
    - Health Behaviors
        - Substance abuse
        - Physical activity
        - Diet
    - Coping Factors
        - Acceptance and resignation to lack of other options
        - Role of social support
        - Presence or absence of social support
    - Psychological Risk and Resilience
        - Sense of personal control or lack of control
        - Chronic stress
        - Social integration
        - Relationship quality
- Biological
    - Physiological Factors
        - Functional decline
        - Physical comorbidities
        - Mental health
        - Role of cumulative stress
        - Premature biologic aging

Their consequent policy prescriptions emphasize that incentives are needed for culture change adoption and promotion to more person-centered, homelike models in high-proportion BIPOC Nursing Homes (NHs). Although not all NHs can adopt homelike models, they can implement culture change care practices, such as consistent assignment, staff empowerment strategies, and flexible work schedules—which have been shown to benefit residents. By adopting culture change and increasing wages, NHs can decrease staff

turnover. Indeed, opportunities for career growth are an important strategy for retention, which is associated with better resident outcomes. They aver that culture change adoption and job pay or career ladder go hand-in-hand because increased pay alone in an undesirable environment will most likely not yield improvements.

Johnson (2024)[5] investigated the leading root causes of health inequity that the COVID-19 pandemic helped shine a light on. She stresses that efforts to advance health equity must be inclusive of all individuals, including members of religious groups that have been minoritized, persons with disabilities, persons living in rural areas, persons living in poverty, and lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons. As Bauermeister and Halem underscore in an article in this issue, LGBTQ+ individuals face significant disparities in health, which may be partially attributable to challenges with health care access, discrimination, mistreatment, and harassment – particularly if they have multiple marginalized identities. Increasingly, the gender-affirming care that could help address health inequities for transgender individuals is under attack from legislation.

Steinman, Santos, and Lorig (2024)[6] investigated Evidence-Based Health Promotion Programs (EBPs) that support older adults where they live, work, pray, play, and age. COVID-19 placed a disproportionate burden on this population, especially those with chronic conditions. In-person EBPs shifted to remote delivery via videoconferencing, phone, and mail during the pandemic, creating opportunities and challenges for older adult health equity.

Findings from 31 EBPs through 198 managers/leaders and 107 organizations suggest remote delivery increases EBP reach by improving access for older adults who are underserved. For programs requiring new software or hardware, challenges remain reaching those with limited access to—or comfort using—technology. Adaptations were to context (e.g., shorter, smaller classes with longer duration) and for equity (e.g., phone formats, autogenerated captioning); content was unchanged except where safety was concerned. Implementation is facilitated by remote delivery guidelines, distance training, and technology support; and hindered by additional time, staffing, and resources for engagement and delivery.

Remote EBP delivery is promising for improving equitable access to quality health promotion. Future policies and practices must support technology access and usability for all older adults.

RECOMMENDATIONS FOR THE APPLICATION PROCESS

Web Portal

As mentioned above, this was the eighth 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 enhancements have consistently been made to further promote efficiency, record retention, and user experience. Further enhancements to the process should be considered to streamline the application and review process.

Recommendation 6: Implement a final validation "checklist" pop-up before providers click final Confirmation & Submission.

PCG is constantly investigating potential improvements to its portal, specifically as it pertains to providers' user experience and ease of application submission. As such, as the penultimate step before final Confirmation and Submission, we recommend implementing a pop-up (clickwrap) asking providers to do a final review to ensure all necessary application components have been addressed. This pop-up will ask

[5] The American Journal of Health Promotion, "The Urgent Need to Advance Health Equity: Past and Present"
[6] Sage Journals, "Remote Evidence-Based Health Promotion Programs During COVID: A National Evaluation of Reach and Implementation for Older Adult Health Equity"

them the following: *Have all Tools been completed? Has supporting documentation been uploaded? Have you verified that all documentation uploaded is openable?*

Recommendation 7: **Enhance the existing "Help" section by making it a distinctive button**.

To better orient providers to the resources available under the "Help" section (User Guide, technical and programmatic contact information, deadlines, HCPF website), consider better highlighting it as a selectable option on the main Homepage rather than as a smaller button at the top of the page. A key aim is to direct homes' focus to the *COPayforPerformance@pcgus.com* email address as being the contact to reach out to with technical (i.e., portal-related) questions, and the *matt.haynes@state.co.us* address is the one to reach out to with program-related questions. Providers will often still direct their requests for technical assistance to Matt personally; the goal is to cut down on the amount of technical outreach he receives.

Recommendation 8: **Recommendation: Conduct a documentation best practices overview refresher**.

Following best practices around uploading supporting documentation continues to be a challenge for providers, particularly newly participating providers. Homes will regularly upload files to the incorrect minimum requirement, upload a singular file containing an entire measure's worth of minimum requirements, and upload files that are unopenable or inaccessible. We thus recommend, via a targeted training or as a carve-out in the existing application trainings, continuing to emphasize the following best practices around supporting documentation uploading:

1. Attach each piece of supporting documentation only to its corresponding minimum requirement (i.e., supporting documentation pertaining to minimum requirement 1-1 should be uploaded to that respective minimum requirement and not 1-2, 1-3, 1-4, etc.).
2. Avoid clustering an entire measure's supporting documentation into a singular document; separate supporting documentation for each respective minimum requirement into individual files.
3. Before final submission, validate each attachment by opening the relevant file to ensure it is openable to the reviewer team. The aim is to cut down on future back-and-forth with providers over inaccessible documents.

RECOMMENDATIONS FOR PROGRAM PARTICIPATION

There was a 20% increase in program participation between 2023 and 2024:

- 2020 – 125 homes
- 2021 – 129 homes
- 2022 – 115 homes
- 2023 – 126 homes
- 2024 – 151 homes

Recommendation 9: **Directly solicit provider feedback on the application process.**

The 2024 Application cycle saw a record number of applications received and scored. We believe a significant factor in this increase was the HCPF 2024 policy change permitting an additional class of providers, providers with Substandard Deficiency Tags (CMS's tags tracking facilities identified as providing substandard quality care) to apply for the 2024 P4P program and to subsequently receive half of the appropriate per-diem payment.

To better understand other factors behind this increase in participation, as well as to better understand obstacles hindering those homes who did not submit applications, we recommend sending out a short survey to the entire group of participating homes requesting feedback on their experiences with the application process in its entirety. Specifically, we recommend requesting feedback on the scoring process, providers' portal experiences, and their ease of IT/technical support access. This survey would ideally be

conducted in early to mid-July, as the application process will be recent and thus fresh in their memories. Additionally, we recommend conducting a specialized survey to first-time participants specifically to collect information around barriers and motivations to participation.

Recommendation 10: **Continue to conduct a second Provider Portal and Application Changes Training in the application year *(supplemental to the existing December training) to maximize the amount of existing and prospective providers reached.***

The addition of the second Provider Portal and Application Changes Training in the 2023 Application year was a definitive value-add. This training is especially valuable in orienting new Administrators to the nuts and bolts of the portal, flagging new measure introductions and changes, and highlighting any newly added resources. PCG received positive feedback from this addition during the April 2024 on-site visits with administrators. We believe that the continuation of holding an additional provider training, staggered strategically around key winter application deadlines, will maximize the amount of existing and prospective nursing home participants reached. This strategy should be continued into 2024.

Recommendation 11: **Continue to emphasize early data collection and application submission.**

Similarly to 2023 and previous years, the 2024 application cycle experienced a moderate volume of last-minute submissions; there is still a large proportion of homes that wait until the very end of the allowed submission period (February 28th at Midnight Mountain Time) to submit their application or request support. PCG believes that reinforcing to homes the value of early document collection and submission versus last minute completion will enable homes more time to reach out with technical assistance should they need it, thus maximizing their applications and potential for points received.

CMS SNF REVIEW

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 FY2019. 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.

2024 AND 2025 PROGRAM UPDATES

2025

In April 2024, under the direction of the Biden-Harris Administration, CMS implemented its updated Nursing Home Minimum Staffing Rule.

- This rule will require all nursing homes that receive federal funding through Medicare and Medicaid to have 3.48 hours per resident per day of total staffing, including a defined number from both registered nurses (0.55 hours per resident per day) and nurse aides (2.45 per resident per day). This means a facility with 100 residents would need at least two or three RNs and at least ten or eleven nurse aides as well as two additional nurse staff (which could be registered nurses, licensed professional nurses, or nurse aides) per shift to meet the minimum staffing standards. Many facilities will need to staff at a higher level based on their residents' needs.
- It will also require facilities to have a registered nurse onsite 24 hours a day, seven days a week, to provide skilled nursing care. The aim is to improve chronic understaffing in Long-Term Care facilities and thereby cut down on resident neglect and improve residents' overall quality of care.

2024

In April 2023, CMS issued its FY2024 proposed rule for the SNF PPS. The proposed rule, finalized July 2023, will:

- Result in a net increase of 3.7%, approximately $1.2 billion in Medicare Part A payments to SNF's in FY2024
  - This estimate reflects $2 billion increase resulting from a 6.1% net market basket update to payment rates; and
  - A 2.3% decrease in FY2024 SNF PPS rates because of the second phase of the Payment-driven Payment Model (PDPM) adjustment recalibration.
- Solidify the adoption of three measures in the SNF QRP, the removal of three measures from the SNF QRP, and the modification of one measure in the SNF QRP. This proposed rule would also make policy changes to the SNF QRP, and begin public reporting of four measures.
- Propose the adoption new quality measures beginning in 2025, 2026, and 2027

Recommendation 12: **Incentivize homes to prematurely abide by CMS's updated minimum staffing requirement.**

The updated 2024 CMS Staffing standard, aimed at reducing the risk of residents receiving unsafe and low-quality care within LTC facilities, is as follows: A total nurse staffing standard of 3.48 hours per resident day, which must include at least 0.55 hours per resident day of direct Registered Nurse (RN) care and 2.45 hours per resident day of direct nurse aide care. Facilities may use any combination of nurse staff (RN, licensed practical nurse [LPN], licensed vocational nurse [LVN], or nurse aide) to account for the additional 0.48 hours per resident day needed. Given these updated requirements, PCG recommends encouraging and incentivizing homes to prematurely abide by these requirements via either of the the existing staffing measures, Staff Engagement or Staff Retention.

Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)[7]

For the 2024 Skilled Nursing Facility Quality Reporting Program, CMS proposes adding four new social determinants of health (SDOH) items and modifying one SDOH assessment item for the SNF QRP. The four new SDOH are across the following categories: (1) Living Situation, (2) Food (2 items), and (3) Utilities. The modified SDOH assessment item is Transportation. This modification is aimed at improving and aligning data collection by clarifying the look-back period for when a patient experienced a lack of reliable transportation, simplifying the response options for the resident, and decreasing provider burden by collecting this item at admission only, instead of at both admission and discharge.

Proposed Changes to Skilled Nursing Facility (SNF) Value-Based Purchasing Program (VBP)

2024

The three key operational and administrative changes CMS is making to the 2024 Skilled Nursing Facility Value-Based Purchasing Program include 1) adopting a measure retention and removal policy to the SNF VBP program, 2) updating the case-mix methodology for the Total Nurse Staffing measure, and 3) a review and correction policy update.

2023

CMS proposed the adoption of the **Discharge Function Score (DC Function) measure** beginning with the FY2025 SNF QRP. This measure assesses functional status by assessing the percentage of SNF

[7] CMS, Fiscal Year (FY) 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1779-P))

residents who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the Minimum Data Set (MDS). This measure would replace the topped-out process measure – the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment/a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure, as discussed below.

CMS proposed the adoption of the **CoreQ: Short Stay Discharge (CoreQ: SS DC) measure** beginning with the FY2026 SNF QRP. This measure calculates the percentage of individuals discharged from an SNF, within 100 days of admission, who are satisfied with their SNF stay. The questionnaire that would be administered under the CoreQ: SS DC measure asks individuals to rate their overall satisfaction with their care using a 5-point Likert scale. The areas of care include: staff, the care received, recommending the facility to friends and family, and how well their discharge needs were met.

CMS proposed the adoption of the **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) measure** beginning with the FY2026 SNF QRP. This measure reports the percentage of stays in which residents in an SNF are up to date with recommended COVID-19 vaccinations in accordance with the Centers for Disease Control and Prevention's (CDC's) most recent guidance. Data would be collected using a new standardized item on the MDS.

CMS proposed to modify **the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure** beginning with the FY2025 SNF QRP. This measure tracks the percentage of healthcare personnel (HCP) working in SNFs who are considered up to date with recommended COVID-19 vaccination in accordance with the CDC's most recent guidance. The prior version of this measure reported only on whether HCP had received the primary vaccination series for COVID-19, while the proposed modification would require SNFs to report the cumulative number of HCP who are up to date with recommended COVID-19 vaccinations in accordance with the CDC's most recent guidance.

Recommendation 13*: *Continue to monitor the plans of the FY2024 SNF VBP and beyond. Continue to drive innovation via the CO P4P-CMS aligned initiatives.

OTHER STATES REVIEW

In addition to a review of SNF program updates, PCG has also explored other states' nursing home VBP programs. In the below section, PCG has highlighted areas that may be useful reference for future areas of focus or other initiatives for the Colorado P4P Program. Through this research, we have noticed that Colorado has one of the most robust nursing home VBP programs in the country. Many programs primarily use quality measures and inspection/survey results. However, the Colorado program is much more qualitative and assesses the quality of life for residents in the state by evaluating things such as dining options, person-directed care, activities programs, and consistent assignments.

TEXAS

Texas's Quality Incentive Payment Program (QIPP)[8], first launched in 2017, is a Directed Payment Program paid out annually by Texas Medicaid. The goal of this program is to help nursing facilities achieve transformation in care quality through innovation. Improvement is measured by several quality measures that are submitted directly by nursing facilities and reviewed by CMS.

[8] Texas Health and Human Services, "Quality Incentive Payment Program for Nursing Homes"

Two classes of Texas nursing facilities serving residents enrolled in STAR+PLUS Medicaid are eligible to participate in QIPP:

- Non-state governmental owned entities (NSGO).
- Privately-owned facilities have a percentage of Medicaid NF days of service that is greater than or equal to 65%.

Texas's QIPP continues to utilize the four primary quality measures it implemented in 2023[9]. These are as follows:

- Component 1: Quality Assurance and Performance Improvement (QAPI).
    - Metric 1: Facility holds QAPI meeting each month that accords with any quarterly state and federal requirements and pursues specific outcomes developed by nursing facility as part of focuses PIP.
- Component 2: Workforce Development
    - Metric 1: Nursing facility maintains four additional hours of registered nurse (RN) staffing coverage per day beyond the CMS mandate.
    - Metric 2: Nursing facility maintains eight additional hours of RN staffing coverage per day beyond the CMS mandate.
    - Metric 3: Nursing Facility has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes.
- Component 3: Minimum Data Set CMS Quality Measures
    - Metric 1: (CMS N015.03) Percent of high-risk residents with pressure ulcers, including unstageable pressure ulcers.
    - Metric 2: (CMS N031.03) Percent of residents who received an antipsychotic medication.
    - Metric 3: (CMS N035.03) Percent of residents whose ability to move independently has worsened.
    - Metric 4: (CMS N024.02) Percent of residents with a urinary tract infection.
- Component 4: Infection Control Program:
    - Metric 1: Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship.

For FY2025, Texas has proposed the following updated QIPP Components[10]:

- Component 1: Hospital Partner Minimum Data Set (MDS) Measures
- Component 2: Workforce Development
- Component 3: Texas Priority MDS Measures
- Component 4: Resident-Focused MDS Measures

OKLAHOMA

Oklahoma has continued to operate its Pay For Performance in Long Term Care program, which it launched in 2019 to replace it previous Focus on Excellence program. The goal of this program is to improve the quality of care for individuals in Oklahoma's Long-term Care Medicaid nursing home facilities.[11]

The program continues to use the same 4 MDS-based quality measures to measure quality of care. They are as follows:

1. N029.02 – Percentage of long-stay residents who lose too much weight,
2. N015.03 – Percentage of long-stay residents with high risk/unstageable pressure ulcers,

[9] Texas Health and Human Services, "Quality Incentive Payment Program (QIPP) Revised Draft Quality Metrics for State Fiscal Year (SFY) 2024"
[10] Texas Health and Human Services, "Quality Incentive Payment Program (QIPP) Requirements State Fiscal Year (SFY) 2025"
[11] Oklahoma Health Care Authority, "Pay for Performance in Long Term Care"

3. N024.02 – Percentage of long-stay residents with a urinary tract infection, and
4. N031.03 – Percentage of long-stay residents who received an antipsychotic medication.

Facilities must meet or exceed the national averages for the measure and show a 5% or better relative improvement from baseline each quarter for the following metrics:[12]

1. Decrease percent of high risk/unstageable pressure ulcers for long-stay residents.
2. Decrease percent of unnecessary weight loss for long-stay residents.
3. Decrease percent of use of anti-psychotic medications for long-stay residents.
4. Decrease percent of urinary tract infection for long-stay residents.

Facilities submit their facility adjusted score and CASPER report quarterly for payment. A facility may earn a minimum of $1.25 per Medicaid patient per day for each quality metric.

Facilities with deficiency of 1 or greater in the program are disqualified from receiving an award that quarter and following quarters until the facility comes into compliance.[13]

MINNESOTA

Since 2016, Minnesota has continued to operate its value-based reimbursement system for nursing facility reimbursement. Under the value-based system, the Minnesota Department of Human Services (DHS) sets facility reimbursement rates based on the cost of providing care to residents. A nursing home facility's rate is tied directly to its care-related costs, up to a limit. If a facility's care-related costs exceed its limits, the facility's rate would not reflect that excess portion of the cost. All facilities receive higher rates when caring for more resource intensive patients.[14]

Facilities must file a cost report with DHS by February 1st of each year. A facility's cost report covers the previous year, and that previous year's report is then used to calculate the facility's rate for the following year. A nursing facility's rate has five components:

1. Direct care
2. Other care
3. Other operating
4. External fixed costs
5. Property

Over half of a facility's rate is made up of the first three components – direct care, other care, and other operating – collectively called the "operating rate". Each rate component is calculated individually.
Currently, DHS and the legislature have continued to attempt to improve and reward nursing facility quality using three main strategies[15]:

1. Minnesota Nursing Home Report Card
    a. This report card provides patient 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 consists of 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 quality measures:
        - Resident Quality of Life
        - Family Satisfaction

[12] Oklahoma Health Care Authority, "OHCA Policies and Rules"
13 Oklahoma Health Care Authority, "Pay for Performance Training Manual"
[14] Minnesota House of Representatives, "Nursing Facility Reimbursement and Regulation"

[15] Minnesota Department of Health Services, "Performance-based Incentive Payments (PIPP) Project Summaries - FY 2024-2025"

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

2. Quality in the Value-based Reimbursement System
    a. Sets a limit on a facility's care-related reimbursement rate using their quality score. A facility with a higher score is subject to higher limits.
3. Incentive Programs: PIPP and QIIP
    a. The Nursing Home Performance-based Incentive Payment Program (PIPP) awards rate increases on a competitive basis. This program is only available to a limited number of facilities each year, offering limited-time rate adjustments to facilities that implement projects that improve quality of care. There are specific performance measures that facilities are assessed on. They are the following:
        i. Skin integrity.
        ii. Fall prevention.
        iii. Nonpharmacological and Person-centered Approaches to improve mobility and decrease the use of antipsychotics
        iv. Reducing acute and chronic conditions to reduce rehospitalizations for short stay residents and implement a revised discharge planning process.
        v. Improve and maintain resident's level of function and meeting their psychosocial needs focusing on all four skill domains: sensory, motor, social and cognition.
        vi. Improve nursing assistant retention rate and in turn improving resident-nursing assistant relationships.
        vii. Improve onboarding program and increase staff retention rate with focus on creating programs for employee recognition, engagement, and communication.
        viii. Home like environment by creating a household model where care is resident directed.
        ix. Resident centered model of care and behavioral management program. Including staff training on dementia care, validation therapy, and the use of non-pharmacological interventions.
        x. Improve residents' quality of life and care by decreasing the prevalence of UTIs.
        xi. Improve residents' care outcomes by strengthening primary care engagement, improving hospice integration, and facilitation employee trainings/mentorships.
    b. The Quality Improvement Incentive Program (QIIP) is a broader reward program open to any facility reimbursed under Medical Assistance.

GEORGIA

The Georgia Nursing Home Quality Initiative[16] operates as a P4P program which involves efforts between Georgia's Department of Community Health (DCH), nursing home providers, and consumer groups. The goal of this initiative is to raise the quality of care for Georgia's nursing home residents. The initiative operates through setting a state-wide set of key performance factors which are tracked and reported on each month by nursing home facilities. This is in addition to an annual customer and employee satisfaction survey. This information is then analyzed and fed back to the facilities, enabling them to take action on improving overall care and satisfaction. Through this initiative facilities are also able to continually compare their performance alongside state and national benchmarks.

[16] Georgia Department of Community Health, "Nursing Home Providers"

The key Quality Measures utilized are as follows[17]:

- Long-stay risk-adjusted hospitalizations per 1,000 resident days
- Long-stay risk-adjusted emergency room visits per 1,000 resident days
- Percentage of long-stay residents that have a need for help with daily activities that has increased
- Percentage of long-stay residents who have pressure ulcers
- Percentage of long-stay residents that lose too much weight
- Percentage of long-stay residents that have a urinary tract infection
- Percentage of long-stay residents that received an antipsychotic medication

Georgia Medicaid reviews facilities every 90 days to determine if they meet the requirements for additional quality payments. Georgia Medicaid financially rewards facilities that maintain a high score on selected quality measures.

DCH uses a platform provided by the national health care applied research and data management firm My InnerView Inc. to calculate each facility's 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, as well as a reduction in staff turnover rates. The reimbursement rates are the following:

Nursing hours reimburses max 1%, My InnerView reimburses a maximum of 2%. ACHA silver, gold, and the Joint Commission accreditation reimburse an additional maximum of 2% in certain areas. Facility reimbursement can range from 2% - 7% depending on what accreditation the facility has received.

CALIFORNIA

California's Skilled Nursing Facility (SNF) Workforce & Quality Incentive Program (WQIP)[18], scheduled to run from 2023 through 2026, incentivizes facilities to improve quality of care, advance equity in healthcare outcomes, and invest in workforce. WQIP succeeds the former Quality and Accountability Supplemental Payment (QASP) program. This was a result of the California legislature amending the Medi-Cal Long Term Care Reimbursement Act to reform the financing methodology applicable to Freestanding Skilled Nursing Facilities (SNFs) Level-B and Adult Freestanding Subacute Facilities Level-B.

WQIP Metrics

- Workforce Metrics Domain
  - Acuity-Adjusted Staffing Hour Metrics Measurement Area
  - Staffing Turnover Metric Measurement Area
- Clinical Metrics Domain
  - Minimum Data Set (MDS) Clinical Metrics Measurement Area
  - Claims-Based Clinical Metrics Measurement Area
- Equity Metrics Domain
  - Medi-Cal Disproportionate Share Measurement Area
  - MDS Racial and Ethnic Data Completeness Measurement Area

In addition to the above metrics, California's WQIP will utilize the following three MDS Quality Measures to assess its homes quality of resident care:

[17] Georgia Governor's Office of Planning and Budget, "Georgia Skilled Nursing Facility (SNF) Quality Incentive Payment Program Technical Report 2: Recommendations for Bonus Payment Allocation Process, the Implementation of a Quality Incentive Program Formula, and an Analysis of the Existing Quality Incentive Payment Program"

[18] California Department of Health Care Services, "Skilled Nursing Facility Workforce & Quality Incentive Program: 2023 Technical Program Guide"

- Percent of High-Risk Residents with Pressure Ulcers, Long Stay
- Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay
- Percent of Residents Who Received an Antipsychotic Medication, Long Stay

NEW YORK

New York's pay for performance program, the Nursing Home Quality Initiative (NHQI), has been operating since 2008. 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.[19]

Nursing facilities are awarded points for quality and performance measures in the components of the Quality Component (quality measures), the Compliance Component (compliance with reporting), and the Efficiency Component (potentially avoidable hospitalizations).

The Quality Component, worth 75 points total, includes 15 quality measures and each measure being worth a maximum of 5 points.

1. Percent of Contract/Agency Staff Used
2. Percent of Current Residents Up to Date with COVID-19 Vaccines with No Medical Contraindications *(new measure in 2023)*
3. Percent of Current Residents Up to Date with COVID-19 Vaccines (*revised measure in 2023*)
4. Percent of Employees Vaccinated for Influenza
5. Percent of Long Stay High-Risk Residents with Pressure Ulcers
6. Percent of Long Stay Low-Risk Residents Who Lose Control of Their Bowel or Bladder
7. Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
8. Percent of Long Stay Residents Who Have Depressive Symptoms
9. Percent of Long Stay Residents Who Lose Too Much Weight
10. Percent of Long Stay Residents Who Received the Pneumococcal Vaccine
11. Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
12. Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
13. Percent of Long Stay Residents with a Urinary Tract Infection
14. Rate of Staffing Hours per Resident per Day
15. Total Nursing Staff Turnover

The compliance component is worth up to a total of 15 points and consists of two measures:

1. NYS Regionally Adjusted Five-Star Quality Rating for Health Inspections
2. Timely Submission of Employee Influenza Immunization Data

The Efficiency Component is worth a total of 10 points and consists of one measure:

1. Potentially Avoidable Hospitalizations

The points for all measures are then summed to create an overall score for each facility. Facilities are also ranked into quintiles based on their overall scores. Quintile one represents the top-performing facilities while quintile five represents the lowest-performing.

[19] New York State, Nursing Home Quality Initiative

UTAH

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program[20] is the state's pay for performance program. Based on performance each year, QII uses general fund money to award performance. In total, the QII program has three components, QII(1), QII(2), and QII(3).

a. QII(1) ensures that quality programs are implemented at the facilities. The QII(1) form contains basic information for each facility to fill out.
b. QII(2) provides incentive for facilities to improve the environment for the residents. Facilities are asked to provide the following information:
    - QII (2)(i) Nurse Call
    - QII (2)(ii) Patient Lift
    - QII (2)(iii) Bathing
    - QII (2)(iv) Patient Life Enhancement
    - QII (2)(v) Educating Staff
    - QII (2)(vi) Transportation
    - QII (2)(vii) Clinical Software, Hardware, and Backup Power
    - QII (2)(viii) HVAC
    - QII (2)(ix) Dining Enhancement
    - QII (2)(x) Outcome Proven Awards
    - QII (2)(xi) Worker Immunizations
    - QII (2)(xii) Patient Dignity
    - QII (2) (xiii) Covid-19 Vaccination Incentive

QII (3) is effectively a final "checklist" form that homes must attest to confirming all submitted data for QII (1) and QII(2). To earn all points for QII(3) a facility must complete all of the QII(1) forms and at least one QII(2) form.

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 does not work for providers. Funding is 100% from the state's general funds.

A facility is compliant if they meet at least 6 out of the 9 CASPER metrics or if they demonstrate improvement in at least 6 out of the 9 metrics. A combination of meeting and demonstrating improvement can also be used. It takes 5-7 months from the time facilities report date for CMS (website where CASPER data is recorded) to organize and publish the data and then analysis will take place in the preceding months.

For FY2024, the Utah legislature increased nursing facility funding via $1 million General Funds appropriated for nursing facility rate increases[21]. This allocated money is available specifically for nursing facilities that submit:

- Meaningful Quality Improvement plan that includes involvement of residents and family (50%)
    - 4 quarterly customer satisfaction surveys
- A plan for culture change (25%)
- An employee satisfaction program (25%)

ALABAMA

The Alabama Nursing Home Association was founded in 1951 and represents 98% of the state's licensed skilled nursing care center. The association comprises of 229 nursing homes and 27,142 nursing home beds across the state. The Alabama Nursing Home Association conducts an annual showcase where

[20] Utah Department of Health and Human Services, "Long-Term Care Resources (NFs and ICFs/ID) QI Incentive Programs"
[21] Utah State Medicaid, "NF General Updates: Presentation to Utah Healthcare Association April 2024 Spring Conference"

homes around the state present best practices they developed to improve the quality of care or quality of life for residents.[22]

The Bureau of Health Provider Standards is the State of Alabama's regulatory agency responsible for licensing and certifying health care facilities. They provide patients with a Health Care Facilities Directory which is an online portal with information including:

- Nursing homes in your geographic area
- Medicare and Medicaid certified homes
- The number of beds available
- Specific types of skilled nursing care

Special Focus Facilities (SFF) are facilities that have a history of serious quality issues. Currently, there is only one SFF nursing home in the state of Alabama.

The Alabama Medicaid Agency offers institutional care coverage for qualified individuals. The qualifications are the following:

- Applicants must be medically approved by Medicare or Medicaid for the nursing facility to be paid
- Applicants must also be a resident of an approved medical institution for at least 30 continuous day to be eligible (except SSI recipients)
- Applicants must have monthly income below a certain limit, set each year in January
- Applicants must be a US citizen and live in Alabama.[23]

OHIO

Ohio's Department of Medicaid operates a VBP program called "Episodes of Care".[24] This episode-based payment model seeks to reduce health care costs and improve quality of care by providing transparency on spend and quality across an entire episode, allowing providers new visibility into their performance and how they compare to peers. An episode of care includes all the care related to a defined medical event (e.g., a procedure or an acute condition), including the care for the event itself, any precursors to the event (such as diagnostic tests or pre-op visits) and follow-up care (such as medications, rehab, or readmission). Episodes, which are built from the perspective of a patient journey, offer a comprehensive view of the care involved in treating a condition for a patient. Ohio Medicaid determines incentive payment amounts based on the annual program year reports and notifies providers when they will pay positive incentives or collective negative incentives.

The follow episodes are covered by being tied to payments:

- Asthma Exacerbation
- Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Perinatal
- Cholecystectomy
- Colonoscopy
- Esophagogastroduodenoscopy (EGD)
- Gastroinestinal (GI) Bleed
- Upper Respiratory Infection (URI)
- Urinary Tract Infection (UTI)

Since 2015, Ohio has launched 43 episodes, 18 of which are currently tied to financial incentives.

[22] Alabama Public Health, Nursing Homes
[23] Alabama Medicaid, Institutional Medicaid: Nursing Home Medicaid Eligibility
[24] Ohio Department of Medicaid, Episode-Based Payments

KANSAS

The mission of the Kansas Department for Aging and Disability Services (KDADS) is to provide high-quality services for Kansas nursing home residents. KDADS implements person-centered care called Promoting Excellent Alternatives in Kansas, or PEAK.[25] PEAK is an incentive program that awards funds to nursing home facilities. PEAK also educates individuals about positive initiatives in Kansas nursing homes. Since 2021, PEAK has developed into PEAK 2.0, a pay-for-performance Medicaid program in an effort to enhance person-centered care practices in Kansas nursing homes.

PEAK is composed of four primary domains, 1) Resident Choice, 2) Staff Empowerment, 3) Home Environment, and 4) Meaningful Life. PEAK provides nursing facilities with the opportunity to earn up to $9.50 per diem add-on 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 nine 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 - $3.00. Accordingly, the per diem add on for the PEAK Incentive can be as much as $3.00.

The program for Medicaid in Kansas is called KanCare. Each month, the state withholds a portion of the payment due to KanCare health plans. At the end of each year, Kansas assesses whether each health plan has met their appropriate targets. If they do, then the health plan will receive a payment back through the KanCare pay-for-performance (P4P) program. The payment health care plans receive is tied to the percentage of required measures those plans meet.[26]

Since 2023 KDADS has been operating its revised version of PEAK, called PEAK: Quality Improvement through Person-Centered Care. The program remains a Medicaid pay-for-performance program. It now features faster escalating per diems and greater flexibility through program levels.

COLORADO

Upon evaluating other states' P4P-like programs, it is evident that Colorado's P4P program is more robust and qualitatively driven than its peers'. Specifically, the majority of the existing peer state P4P programs exclusively utilize clinical metrics, while Colorado's program focuses substantially on measuring residents' quality of life. In Colorado, data is collected across all facets of residents' day to day experiences, including Dining, Home Décor, Volunteer Opportunities, and Connection and Meaning. This provides a comprehensive view into Colorado homes' provision of care wholistically, not one based solely on clinical outcomes. The CO P4P Program should continue to emphasize capturing a mix of quantitative-qualitative metrics of nursing home residents' quality of life and quality of care, while also continuing to explore portal and provider training enhancements to maximize program efficacy.

[25] Kansas State University Center on Aging, "PEAK Guidebook: Quality Improvement Through Person-Centered CARE 2024-2025"

[26] Medicaid & Maternal & Child Health (MCH) Alignment, Medicaid & Maternal & Child Health (MCH) Alignment: Priorities & Measures

BEST PRACTICES

It is valuable for the Department to continue to look to peer local, state, and federal nursing facility best practices for quality of care, quality of life and facility management. The below section provides details on best practices across the national landscape.

THE WHITE HOUSE'S STANDARDS

In April 2024, the Biden-Harris Administration implemented its updated Nursing Home Minimum Staffing Rule.[27] This rule will require all nursing homes that receive federal funding through Medicare and Medicaid to have 3.48 hours per resident per day of total staffing, including a defined number from both registered nurses (0.55 hours per resident per day) and nurse aides (2.45 per resident per day). This means a facility with 100 residents would need at least two or three RNs and at least ten or eleven nurse aides as well as two additional nurse staff (which could be registered nurses, licensed professional nurses, or nurse aides) per shift to meet the minimum staffing standards. Many facilities will need to staff at a higher level based on their residents' needs. It will also require facilities to have a registered nurse onsite 24 hours a day, seven days a week, to provide skilled nursing care. The aim is to improve chronic understaffing in Long-Term Care facilities and thereby cut down on resident neglect and improve residents' overall quality of care.

Relatedly, CMS is developing a $75 million national nursing home staffing campaign to increase the number of nurses in nursing homes, thereby enhancing residents' health and safety. Through this campaign, CMS will be providing financial incentives for nurses to work in nursing homes.

The President's FY2024 Budget[28] improves the safety and quality of nursing home care, addresses the backlog of complaint surveys from nursing home residents, expands financial penalties for underperforming facilities, requires greater transparency of nursing facility ownership, and increases the inspection of facilities with serious safety deficiencies. Additionally, the Budget proposes to shift funding for nursing home surveys from discretionary to mandatory beginning in 2026 and increase funding to cover 100 percent of statutorily-mandated surveys, which will guard against negligent care and ensure that Americans receive high quality, safe services within these facilities. The Biden-Harris Administration also continues to prioritize its efforts to crack down on homes that "commit fraud, endanger patient safety, or prescribe drugs they don't need."

CMS under the direction of President Biden's administration has continued to develop and build upon its initiatives launched in 2022 to ensure that residents get the quality health care they need. These initiatives are designed to help ensure adequate staffing, dignity and safety in their accommodations, and quality care. The initiatives' key principles are as follows:[29]

- ✓ ***Establish a Minimum Nursing Home Staffing Requirement.*** The adequacy of a nursing home's staffing is the measure most closely linked to the quality-of-care residents receive. For example, a recent study of one state's nursing facilities found that increasing registered nurse staffing by just 20 minutes per resident day was associated with 22% fewer confirmed cases of COVID-19 and 26% fewer COVID-19 deaths. CMS intends to propose minimum standards for staffing adequacy that nursing homes must meet. CMS will conduct a new research study to determine the level and type of staffing needed to ensure safe and quality care and will issue proposed rules within one year. Establishing a minimum staffing level ensures that all nursing home residents are provided safe, quality care, and that workers have the support they need to provide high-quality care. Nursing homes will be held accountable if they fail to meet this standard.

[27] The White House Briefing Room, "Fact Sheet: Vice President Harris Announces Historic Advancements in Long-Term Care to Support the Care Economy"
[28] The White House Briefing Room, "FACT SHEET: The President's Budget Protects and Increases Access to Quality, Affordable Healthcare"
[29] The White House Briefing Room, "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes"

- ✓ ***Reduce Resident Room Crowding.*** Most nursing home residents prefer to have private rooms to protect their privacy and dignity, but shared rooms with one or more other residents remain the default option. These multi-occupancy rooms increase residents' risk of contracting infectious diseases, including COVID-19. CMS will explore ways to accelerate phasing out rooms with three or more residents and to promote single-occupancy rooms.
- ✓ ***Strengthen the Skilled Nursing Facility ("SNF") Value-Based Purchasing ("VBP") Program.*** The SNF-VBP program awards incentive funding to facilities based on quality performance. CMS has begun to measure and publish staff turnover and weekend staffing levels, metrics which closely align with the quality of care provided in a nursing home. CMS intends to propose new payment changes based on staffing adequacy, the resident experience, as well as how well facilities retain staff.
- ✓ ***Reinforce Safeguards against Unnecessary Medications and Treatments***. Thanks to CMS' National Partnership to Improve Dementia Care in Nursing Homes, the nation has seen a dramatic decrease in the use of antipsychotic drugs in nursing homes in recent years. However, inappropriate diagnoses and prescribing still occur at too many nursing homes. CMS will launch a new effort to identify problematic diagnoses and refocus efforts to continue to bring down the inappropriate use of antipsychotic medications.
- ✓ ***Adequately Fund Inspection Activities.*** For over seven years, funding to conduct health and safety inspections has remained flat while the number of complaints about nursing homes has surged. To protect residents and crack down on unsafe nursing homes, President Biden will call on Congress to provide almost $500 million to CMS, a nearly 25% increase, to support health and safety inspections at nursing homes.
- ✓ ***Beef up Scrutiny on More of the Poorest Performers.*** CMS's Special Focus Facility (SFF) program identifies the poorest-performing nursing homes in the country for increased scrutiny in an effort to immediately improve the care they deliver. The SFF program currently requires more frequent compliance surveys for program participants, which must pass two consecutive inspections to "graduate" from the program. Even after a facility graduates from the program, CMS will now continue close scrutiny of the facility for at least three years, helping ensure the homes consistently maintain compliance with all safety requirements. The SFF program will be overhauled to improve care more quickly for the affected residents, including changes that will make its requirements tougher and more impactful. CMS will also make changes that allow the program to scrutinize more facilities, by moving facilities through the program more quickly. Facilities that fail to improve will face increasingly larger enforcement actions, including termination from participation in Medicare and Medicaid, when appropriate. CMS is also increasing its engagement with these poor-performing nursing ho*mes through direct and immediate outreach by CMS officials upon their selection as an SFF to help them understand how to improve and access support resources.*
- ✓ ***Expand Financial Penalties and Other Enforcement Sanctions.*** CMS will expand the instances in which it takes enforcement actions against poor-performing facilities based on desk reviews of data submissions, which will be performed in addition to on-site inspections. In July 2021, CMS rescinded a Trump Administration change that lowered penalty amounts on bad actor nursing homes for harmful deficiencies by imposing only a one-time fine, instead of more aggressive per-day fines that charge for each day a facility is out of compliance. CMS will now explore making such per-day penalties the default penalty for non-compliance. CMS will also use data, predictive analytics, and other information processing tools to improve enforcement. President Biden is also calling on Congress to raise the dollar limit on per-instance financial penalties levied on poor-performing facilities, from $21,000 to $1,000,000.
- ✓ ***Increase Accountability for Chain Owners of Substandard Facilities.*** President Biden is calling on Congress to give CMS new authority to require minimum corporate competency to participate in Medicare and Medicaid programs, enabling CMS to prohibit an individual or entity from obtaining a Medicare or Medicaid provider agreement for a nursing home (new or existing) based on the Medicare compliance history of their other owned or operated facilities (previous or existing). He is further calling on Congress to expand CMS enforcement authority at the ownership level, enabling

CMS to impose enforcement actions on the owners and operators of facilities even after they close a facility, as well as on owners or operators that provide persistent substandard and noncompliant care in some facilities, while still owning others.

- ✓ ***Provide Technical Assistance to Nursing Homes to Help them Improve.*** CMS currently contracts with Quality Improvement Organizations that help providers across the health care spectrum make meaningful quality of care improvements. CMS will ensure that improving nursing home care is a core mission for these organizations and will explore pathways to expand on-demand trainings and information sharing around best practices, while expanding individualized, evidence-based assistance related to issues exacerbated by the pandemic.
- ✓ ***Create a Database of Nursing Homeowners and Operators.*** CMS will create a new database that will track and identify owners and operators across states to highlight previous problems with promoting resident health and safety. This registry will use information collected through provider enrollment and health and safety inspections to provide more information about prospective owners and operators to states. Giving the public a resource to better understand owners' and operators' previous violations will empower states to better protect the health and safety of residents.
- ✓ ***Improve Transparency of Facility Ownership and Finances.*** CMS will implement Affordable Care Act requirements regarding transparency in corporate ownership of nursing homes, including by collecting and publicly reporting more robust corporate ownership and operating data. It will also make this information easier to find on the Nursing Home Care Compare website.
- ✓ ***Enhance Nursing Home Care Compare:*** CMS will implement a range of initiatives to improve Nursing Home Care Compare, the rating website designed to help families pick a facility for their loved ones. Under the Biden-Harris Administration's leadership, CMS has already published new measures on Care Compare, which allow users to consider nursing home staff turnover, weekend staffing levels, and other important factors in their decision-making process. When the new minimum staffing requirement comes online, Care Compare will also prominently display whether a facility is meeting these minimum staffing requirements. CMS will further improve Care Compare by improving the readability and usability of the information displayed—giving you and your family insight into how to interpret key metrics. Finally, CMS will ensure that ratings more closely reflect data that is verifiable, rather than self-reported, and will hold nursing homes accountable for providing inaccurate information. The President is calling on Congress to give CMS additional authority to validate data and take enforcement action against facilities that submit incorrect information.
- ✓ ***Examine the Role of Private Equity.*** Private equity investors are increasingly playing a growing role in the nursing home sector. Published research indicates that facility ownership by investment groups leads to worse outcomes while costing taxpayers more—particularly as these owners have sought to cut expenses at the cost of patient health and safety, including during the COVID-19 pandemic. HHS and other federal agencies will examine the role of private equity, real estate investment trusts (REITs), and other investment ownership in the nursing home sector and inform the public when corporate entities are not serving their residents' best interests.
- ✓ ***Ensure Nurse Aide Training is Affordable***. Lowering financial barriers to nurse aide training and certification will strengthen and diversify the nursing home workforce. CMS will establish new requirements to ensure nurse aide trainees are notified about their potential entitlement to training reimbursement upon employment. CMS will further work with states to ensure reimbursement is being distributed and that free training opportunities are widely publicized.
- ✓ ***Support State Efforts to Improve Staffing and Workforce Sustainability***. Strengthening the nursing home workforce requires adequate compensation as well as a realistic career ladder. CMS will develop a template to assist and encourage States requesting to tie Medicaid payments to clinical staff wages and benefits, including additional pay for experience and specialization.
- ✓ ***Launch National Nursing Career Pathways Campaign.*** CMS, in collaboration with the Department of Labor, will work with external entities—including training intermediaries, registered apprenticeship programs, labor-management training programs, and labor unions—to conduct a

robust nationwide campaign to recruit, train, retain, and transition workers into long-term care careers, with pathways into health-care careers like registered and licensed nurses.

- ✓ ***Continued COVID-19 Testing in Long-term Care Facilities.*** Throughout the pandemic, the Biden-Harris Administration has provided approximately 3 million tests per week to all Medicare- and Medicaid-certified nursing homes and thousands more assisted living facilities, supporting outbreak testing and regular testing of staff. HHS will continue to support this key mitigation strategy for vulnerable residents and the staff that care for them.
- ✓ ***Continued COVID-19 Vaccinations and Boosters in Long-term Care Facilities.*** The Biden-Harris Administration has provided the full support of the federal government to states in ensuring that staff and residents across long-term care facilities have access to vaccinations and booster shots. Today, facilities are required to ensure staff are vaccinated and more than 87.1% of residents have received their primary series. CDC continues to offer all facilities the ability to be matched with a federal pharmacy partner to host an on-site vaccination clinic. CMS has reached out to thousands of these facilities directly to offer support, and the Agency for Healthcare Research and Quality has made a wide set of tools available. HHS will continue to promote access to these clinics and efforts to integrate vaccinations into routine services, incentivize vaccinations through provider quality payment programs, and continue to provide a full range of resources to continue to build confidence in the vaccine.
- ✓ ***Strengthen Requirements for On-site Infection Preventionists.*** CMS will clarify and increase the standards for nursing homes on the level of staffing facilities need for on-site infection prevention employees, undoing the Trump Administration's changes to these requirements to help improve resident health and safety.
- ✓ ***Enhance Requirements for Pandemic and Emergency Preparedness.*** Both the pandemic and the increase in natural disasters have demonstrated how critical proactive emergency preparedness is to keeping residents of nursing homes safe. CMS is examining and considering changes to emergency preparedness requirements and is working to bolster the resiliency of the health care sector as part of an Administration-wide effort to be ready for the next pandemic and the next weather-related emergencies.
- ✓ ***Integrate Pandemic Lessons into Nursing Home Requirements.*** The pandemic has underscored the need for resident-centered updates to nursing homes' requirements of participation in Medicare and Medicaid. CMS will integrate new lessons on standards of care into nursing home requirements around fire safety, infection control, and other areas, using an equity lens.

AMERICAN HEALTH CARE ASSOCIATION (AHCA) AND NATIONAL CENTER FOR ASSISTED LIVING (NCAL) REGULATORY GUIDANCE AND RESOURCES

In 2024, the AHCA/NCAL Regulatory and Clinical Team circulated to long-term care (LTC) providers recently published resources[30] aiming to support them and ensure they have the tools to stay compliant with relevant LTC regulatory requirements. The key resources are as follows:

- Abuse Tip Sheets
- CPR Tip Sheets
- Meeting the Infection Preventionist Requirements Tip Sheets
- Meeting Immunization Requirements Tip Sheets
- Meeting Linen Requirements Tip Sheets

[30] American Health Care Association and National Center for Assisted Living, "AHCA/NCAL Provides More Regulatory Resources for LTC Providers in 2024"

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' (DHHS) QUALITY & PATIENT SAFETY PROGRAMS BY SETTING: LONG-TERM CARE

DHHS's Agency for Healthcare Research and Quality (AHRQ) developed and approved the below curricula, training modules, and surveys to maximize long-term care efficacy and fidelity.[31]

CAHPS® Nursing Home Survey was developed by AHRQ and designed to measure patients' experiences of their care, including communication with doctors and nurses, responsiveness of staff, and other indicators of safe, high-quality care. The surveys are developed from the patient's perspective on what's important to measure.

CUSP Toolkit to Reduce CAUTI and Other HAIs In Long-Term Care Facilities includes customizable training tools that build the capacity to address safety issues by combining clinical best practices, the science of safety, and attention to safety culture. Created for clinicians by clinicians, the toolkit includes training tools to make care safer by improving the foundation of how clinical team members work together.

Falls Management Program: A Quality Improvement Initiative for Nursing Facilities is an interdisciplinary quality improvement initiative to assist nursing facilities in providing individualized, person-centered care and improving their fall care processes and outcomes through educational and quality improvement tools.

Improving Patient Safety in Long-Term Care Facilities is a training curriculum for front-line personnel in nursing home and other long-term care facilities to help them detect and communicate changes in a resident's condition and prevent and manage falls. Includes an Instructor Guide and separate student workbooks.

Nursing Home Antimicrobial Stewardship Modules are field-tested, evidence-based modules that can help nursing homes develop antibiotic stewardship programs to help them use and prescribe antibiotics appropriately. Appropriate antibiotics use can reduce antimicrobial resistance and help retain the effectiveness of treatments for infection, which are a common threat to resident safety.

Nursing Home Survey on Patient Safety Culture is a staff-administered survey that helps nursing homes assess how their staff perceive various aspects of safety culture.

Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention is a team training curriculum to help nursing homes with electronic medical records reduce the occurrence of pressure ulcers.

TeamSTEPPS® Long-Term Care Version is a core curriculum initially developed for use in hospitals and adapted to other settings. It is a customizable "train the trainer" program plus specialized tools to reduce risks to patient safety by training clinicians in teamwork and communication skills.

Toolkit to Educate and Engage Residents and Family Members helps nursing homes encourage an open and respectful dialogue between nurses and prescribing clinicians and residents and family members and helps residents and family members participate in their care.

Toolkit To Improve Antibiotic Use in Long-Term Care helps nursing homes improve antibiotic stewardship and promote safer prescribing.

Understanding Omissions of Care in Nursing Homes helps nursing home staff understand how omissions of care are defined in a way that is meaningful to stakeholders, including residents and caregivers, and actionable for research or improving quality of care.

[31] DHHS, AHRQ's Quality & Patient Safety Programs by Setting: Long-Term Care

NATIONAL ACADEMIES' NURSING HOME CARE IMPROVEMENT OBJECTIVES

The National Academies of Sciences, Engineering and Medicine released its 2022 updated report on key objectives and necessary improvements to nursing home care delivery, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*. The guiding principles are highlighted below.[32]

Preparing for Emergencies

As of June 2024, 171,576 nursing home residents have died of COVID-19.[33] Even before the pandemic, many facilities did not have adequate expertise and experience in infection prevention and control practices. Moving forward, nursing homes should be included in emergency planning, preparedness, and response at the federal, state, and local levels, the report says. This will help ensure nursing homes have access to vital resources, such as personal protective equipment, and that they receive ongoing assistance, education, and training on infection prevention and control as well as general preparedness for future natural disasters or public health emergencies.

Improving Resident Care

Achieving person-centered care that reflects resident values and preferences starts with the resident care planning process. Nursing homes, with CMS oversight, should identify and accurately document the care preferences of residents and their families. Staff should ensure the care plan addresses medical, psychosocial, and behavioral health needs, and should revisit this plan at least quarterly. Federal agencies, academic institutions, and private foundations should fund research on the care models and specific factors (such as the physical environment and staffing ratios) that best meet the needs of specific populations. In addition, the report recommends identifying pathways to provide financial incentives to nursing homes for the adoption of certified electronic health records, which can improve the coordination of care.

The nation's nursing home infrastructure is aging, the report adds, and facility size and room sharing could be major predictors of infection rates. Nursing homeowners, with the support of CMS and other federal agencies, should construct and renovate facilities to provide smaller, more home-like environments, which may include single-occupancy bedrooms and private bathrooms. These changes can help prevent the spread of infection while enhancing the quality of life for residents.

Building a High-Quality Workforce

To build a nursing home workforce that is well prepared, empowered, and appropriately compensated, the report recommends increasing the numbers and the qualifications of all types of nursing home workers. CMS should establish minimum education and national competency standards for a variety of workers. While this may be challenging amid COVID-19-related staffing shortages, enhancing requirements will improve the quality of care, further professionalize the workforce, and in turn, contribute to the desirability of working in a nursing home. CMS should immediately implement requirements for 24/7 registered nurse staffing and a full-time social worker in all nursing homes. To inform future staffing requirements, the U.S. Department of Health and Human Services (HHS) should fund research on the minimum and optimum staffing levels for nurses, therapists, recreational staff, social workers, and other employees.

Nursing homes should provide ongoing training in diversity and inclusion for all workers and leadership and provide family caregivers with resources and training as needed or desired. To recruit and retain all types of staff, nursing homes should ensure competitive wages and benefits, including health insurance, childcare, and sick pay.

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[32] National Academies of Science, Engineering and Medicine, "Wide-Ranging Systemic Changes Needed to Transform Nursing Homes to Meet Needs of Residents, Families, and Staff"
[33] CMS, "COVID-19 Nursing Home Data"

Strengthening Financing and Payment

The current approach to financing nursing home care is highly fragmented. The federal-state Medicaid program is the dominant payer of long-stay nursing home care, while the federal Medicare program only covers short-stay post-acute care. Services such as hospice care are paid separately and are not well integrated into standard nursing home care. Private insurance coverage for long-term care is limited, and relatively few people can afford to pay out of pocket for an extended nursing home stay. The report calls on HHS to study the design of a new long-term care benefit. The report also provides recommendations to improve the value of care by linking payments more closely to quality using alternative payment model demonstration projects for long-stay care and bundled payment arrangements for short-stay post-acute care.

Increasing Transparency and Accountability

The report recommends collecting, auditing, and making publicly available detailed facility-level data on the finances, operations, and ownership of all nursing homes. This will inform evaluations of how Medicare and Medicaid payments are spent, and the impact of ownership models and spending patterns on the quality of care. The report also calls for CMS and states to improve oversight of nursing homes, to avoid a repeat of the failures that occurred during the COVID-19 pandemic. It recommends that federal and oversight agencies impose enforcement actions such as denial of new or renewed licensure on owners with a pattern of poor-quality care across facilities. As part of its efforts to strengthen oversight of nursing homes, CMS should also ensure state survey agencies have the capacity, organizational structure, and resources for their responsibilities, including monitoring of nursing homes, investigation of complaints, and enforcement of regulations.

Changing Societal Views on Aging

The COVID-19 pandemic highlighted nursing home residents' vulnerability and the pervasive ageism evident in undervaluing the lives of older adults, the report says. High-quality care cannot be delivered without a major overhaul of worker training and support, the culture within nursing homes, and how society views aging in general. Nursing home leaders should drive these changes.

"Aging should not be something to be dreaded, but something to be revered, and as such, nursing homes should provide the highest quality and compassionate care to enhance the lives of those in their care. This report delivers a blueprint to build a system of nursing homes that truly centers the lives of older adults and gives them respect, dignity, and protection," said Victor J. Dzau, president of the National Academy of Medicine. "The COVID-19 pandemic highlighted the persistent inequities and inadequacies in American nursing home care, clearly illustrating that this system is broken. Addressing these vulnerabilities must include building a high-quality workforce, ensuring a more rational payment system, and directly addressing ageism so we can provide care that improves, not only sustains, the lives of our aging loved ones."

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, with overall ratings ranging from one star to five stars, and 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.

Note: It is important to note that the 5-star rating data below was pulled in June 2024 but contains ratings from between 2020 and 2024. Ratings are typically done on a 16-month cycle; however, this timeline was impacted due to the pandemic. Because of this, the 5-star rating may not align to this P4P program year.

Table 3, below, displays each applicant's CMS 5-star rating in addition to their P4P application self-score and the final review score. Out of the 126 applications received, 1 (1%) had a 0-star rating, 12 (10%) had a 1-star rating, 26 (21%) had a 2-star rating, 22 (17%) had a 3-star rating, 34 (27%) had a 4-star rating, and 30 (25%) had a 5-star rating. It can be determined that a 0, 1, or 2-star rating did not deter facilities from applying for the 2023 Pay for Performance program.

Table 3. CMS 5-Star Rating Data with 2024 P4P Scores

Provider Name	2024 Self Score	2024 Reviewer Score	5-Star Rating
Adara Living	80	62	1
Allison Care Center	100	82	4
Amberwood Post Acute	94	76	3
Arborview Senior Community	87	84	2
Ardent Health and Rehabilitation Center	80	77	1
Arvada Care and Rehabilitation	83	78	5
Avamere Transitional Care and Rehabilitation-Malley	84	81	1
Bent County Healthcare Center	85	68	3
Berkley Manor Care Center	67	45	2
Berthoud Care and Rehabilitation	97	90	4
Beth Israel at Shalom Park	92	89	5
Bethany Nursing and Rehab Center	27	27	1
Boulder Canyon Health and Rehabilitation	100	90	5
Briarwood Health Care Center	81	67	2

Provider Name	2024 Self Score	2024 Reviewer Score	5-Star Rating
Brighton Care Center	92	85	3
Broadview Health and Rehabilitation Center	89	74	3
Brookshire Post Acute	42	20	2
Brookside Inn	91	91	2
Bruce McCandless CO State Veterans Nursing Home	88	80	4
Cambridge Care Center	84	66	3
Casey's Pond Senior Living LTC	80	71	4
Castle Peak Senior Life and Rehabilitation	81	60	2
Cedars Healthcare Center	84	49	1
Centre Avenue Health & Rehab	88	79	5
Centura Health- Medalion Health Center	96	88	5
Centura Health- Progressive Care Center	54	37	2
Cherrelyn Healthcare Center	61	12	1
The Suites at Someren Glen	85	78	2
Clear Creek	90	75	1
Colonial Health and Rehabilitation Center	72	63	1
Colorado State Veterans Nursing Home- Rifle	89	65	4
Colorado Veterans Community Living Center at Homelake	67	67	5
Colorow Care Center	83	76	3
Columbine Manor Care Center	32	14	3
Columbine West Health and Rehab Facility	85	79	5
Cottonwood Rehabilitation and Healthcare	93	91	4
Creekside Village Health and Rehabilitation Center	75	61	2
Crestmoor Health and Rehabilitation	98	95	3
Crowley County Nursing Center	85	71	2
Denver North Care Center	99	71	2
Desert Willow Health and Rehabilitation Center	72	69	1
Devonshire Acres	83	73	3
Eagle Ridge of Grand Valley	59	38	4
Eben Ezer Lutheran Care Center	79	70	1
Elevation Health and Rehabilitation Center	96	67	2
Elk Ridge Health and Rehabilitation Center	71	40	1
Englewood Post Acute and Rehabilitation	91	78	4
Fairacres Manor, Inc.	97	72	2
Falcon Heights Health and Rehabilitation Center	79	63	1
Forest Ridge Senior Living, LLC	82	68	5
Forest Street Compassionate Care Center	42	19	2
Fountain View Health and Rehabilitation	86	77	3
Glenwood Springs Health Care	73	47	2
Good Samaritan Society - Fort Collins Village	75	64	3

Provider Name	2024 Self Score	2024 Reviewer Score	5-Star Rating
Good Samaritan Society- Loveland Village	66	60	4
Grace Manor Care Center	79	52	4
Grand River Health Care Center	92	79	5
Gunnison Valley Health Senior Care Center	72	48	4
Hallmark Nursing Center	35	44	3
Hampden Hills Post Acute	92	92	2
Harmony Pointe Nursing Center	86	76	2
Health Center at Franklin Park	83	75	2
Highline Rehabilitation and Care Community	87	85	3
Hilltop Park Post Acute	90	73	2
Holly Heights Care Center	88	84	5
Holly Nursing Care Center	95	84	3
Horizons Care Center	89	74	2
Irondale Post Acute	95	79	4
Julia Temple Healthcare Center	97	97	5
Junction Creek Health and Rehabilitation Center	84	70	2
Juniper Village- The Spearly Center	87	60	1
Kiowa Hills Health and Rehabilitation Center	78	60	1
La Villa Grande Care Center	77	30	2
Lakeside Post Acute	58	29	4
Lakewood Villa	91	64	1
Lamar Estates, LLC	43	29	5
Larchwood Inns	79	63	3
Lemay Avenue Health and Rehabilitation Facility	80	72	5
Life Care Center of Aurora	70	38	2
Life Care Center of Colorado Springs	35	29	4
Life Care Center of Evergreen	64	58	5
Life Care Center of Greeley	85	72	5
Life Care of Littleton	78	51	3
Life Care Center of Longmont	77	56	3
Linden Place Health and Rehabilitation Center	89	81	2
Littleton Care and Rehabilitation Center	90	82	5
Lowry Hills Care and Rehabilitation	81	71	1
Mantey Heights Rehabilitation and Care Center	54	35	1
Mapleton Post Acute	86	70	2
Mesa Vista Healthcare DBA Boulder Post Acute	91	88	4
Monte Vista Estates, LLC	78	68	1
Mountain View Post Acute	94	51	1
Mountain Vista Health Center	91	86	3
North Shore Health and Rehab Facility	69	60	2
Orchard Valley Health and rehab	86	66	1
Paonia Care and Rehabilitation Center	71	28	1

Provider Name	2024 Self Score	2024 Reviewer Score	5-Star Rating
Park Forest Care Center, Inc.	93	78	1
Parkview Care Center	95	88	3
Pelican Pointe Health and Rehabilitation Center	71	63	2
Pikes Peak Center	75	75	1
Pine Ridge Rehabilitation and Healthcare Center	88	61	4
Pioneer Health Care Center	90	68	2
Poudre Canyon Health and Rehabilitation Center	89	89	1
Prestige Care Center of Pueblo	73	55	3
Red Cliffs Post Acute Center	69	44	1
Regent Park Nursing and Rehabilitation	83	47	5
Rehab and Nursing Center Of The Rockies	91	88	5
Rehabilitation Center at Sandalwood	82	74	4
Ridgeview Post Acute Rehabilitation Center	94	83	2
Rio Grande Rehabilitation and Healthcare Center	97	89	2
River Valley Rehabilitation and Healthcare Center	86	79	1
Riverbend Health Care Center	93	77	3
Rock Canyon Respiratory and Rehabilitation	96	74	2
Rowan Community	96	73	3
Sandrock Ridge Care and Rehab	70	46	1
Silver Heights	88	57	3
Skylake Post Acute	83	51	1
Skyline Ridge Nursing and Rehabilitation Center	80	46	2
South Platte Health and Rehabilitation Center	97	70	4
South Valley Post Acute Rehabilitation	97	85	5
Southeast Colorado Hospital LTC Center	70	58	3
Spanish Peaks Veterans Community Living	83	80	2
Spring Village Care Center	87	46	1
St Paul Health Center	76	69	1
Sterling Health and Rehabilitation Center	64	51	2
Suites at Clermont Park Care Center	84	60	5
Summit Rehabilitation and Care Community	92	77	3
Sundance Skilled Nursing and Rehabilitation	86	69	2
Sunny Vista Living Center	31	17	3
The Gardens	97	63	5
The Green House Homes at Mirasol	76	70	2
The Heights Post Acute	76	75	1
The Pavilion at Villa Pueblo	92	44	2
The Peaks Care Center	50	50	5
The Suites Parker	61	55	1
The Valley Rehabilitation and Healthcare Center	99	93	5
The Villas at Sunny Acres	90	81	3
Trinidad Rehabilitation and Healthcare Center	98	89	1

Provider Name	2024 Self Score	2024 Reviewer Score	5-Star Rating
University Heights Rehab and Care Community	85	74	1
University Park Care Center	67	64	3
Uptown Health Care Center	89	70	3
Valley Manor Care Center	89	67	2
Valley View Health Care Center Inc.	92	69	1
Valley View Villa	60	29	5
Vista Grande Rehabilitation and Health Care	88	83	5
Walsh Healthcare Center	87	79	5
Washington County Nursing Home	75	67	2
Western Hills Health Care Center	81	55	4
Westlake Care Community	92	78	4
Westlake Lodge Health and Rehabilitation Center	69	66	4
Wheatridge Manor Care Center	92	84	3

Table 4 shows the average P4P scores and ranges for each of the 5-star rating groups. Based on this analysis, CMS 5-star rating is not necessarily a useful predictive indicator of success on the P4P application.

Table 4. 5-Star Ratings and P4P Score Average and Range.

5-Star Rating	P4P Score Average	P4P Score Range	# of Homes
0	0	0	0
1	64.1	22-95	35
2	67.9	24-93	39
3	65.9	27-85	30
4	72.6	26-93	21
5	60.9	7-95	26

RECOMMENDATIONS

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

Recommendation 1: *More clearly delineate "evidence" in all relevant instances across measures.*

Recommendation 2: *Emphasize that correct testimonial dates are a requirement.*

Recommendation 3*: Streamline the language of Measure 8.2 (Physical Environment – Noise Management) by eliminating redundancy.*

Recommendation 4: *Conduct a Quality Measure best practices overview and refresher.*

Recommendation 5: *Clarify in the prerequisite measure language that to qualify, Family and Resident Satisfaction Surveys must contain, at minimum, one respondent contacted and one respondent reply.*

Recommendation 6: *Clarify the intentions and expectations of both the Equity Measure's Initiatives and Accessibility sections.*

Recommendation 7: *Implement a final validation "checklist" pop-up before providers click final Confirmation & Submission.*

Recommendation 8: *Enhance the existing "Help" section by making it a distinctive button.*

Recommendation 9: *Conduct a documentation best practices overview refresher.*

Recommendation 10: *Directly solicit provider feedback on the application process.*

Recommendation 11: *Continue to conduct a second Provider Portal and Application Changes Training in the application year (supplemental to the existing December training) to maximize the amount of existing and prospective providers reached.*

Recommendation 12: *Continue to emphasize early data collection and application submission.*

Recommendation 13*: Communicate CMS's updated Minimum Staffing Standards for Long-Term Care Facilities to P4P Committee and encourage alignment across homes' staffing models.**

**UPDATE based on Richard's 6/17 feedback: Incentivize homes to prematurely abide by CMS's updated minimum staffing requirement.*

Recommendation 14*: Continue to monitor the plans of the FY2024 SNF VBP and beyond. Continue to drive innovation as many of the measures that have been implemented by the CO P4P are aligned with future CMS initiatives.*

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 5.

Table 5. Summary of Recommendations

Application	Portal	Programmatic
Recommendation 1: *More clearly delineate "evidence" in all relevant instances across measures.* ***Recommendation 2:*** *Emphasize that correct testimonial dates are a requirement.* ***Recommendation 3:*** *Streamline the language of Measure 8.2 (Physical Environment – Noise Management) by eliminating redundancy.* ***Recommendation 4:*** *Conduct a Quality Measure best practices overview and refresher.* ***Recommendation 5:*** *Clarify in the prerequisite measure language that to qualify, Family and Resident Satisfaction Surveys must contain, at minimum, one respondent contacted and one respondent reply.* ***Recommendation 6:*** *Clarify the intentions and expectations of both the Equity Measure's Initiatives and Accessibility sections.*	***Recommendation 7:*** *Implement a final validation "checklist" pop-up before providers click final Confirmation & Submission.* ***Recommendation 8:*** *Enhance the existing "Help" section by making it a distinctive button.* ***Recommendation 9:*** *Conduct a documentation best practices overview refresher.*	***Recommendation 10:*** *Directly solicit provider feedback on the application process.* ***Recommendation 11:*** *Continue to conduct a second Provider Portal and Application Changes Training in the application year (supplemental to the existing December training) to maximize the amount of existing and prospective providers reached.* ***Recommendation 12:*** *Continue to emphasize early data collection and application submission.* ***Recommendation 13:*** *Incentivize homes to prematurely abide by CMS's updated minimum staffing requirement.* **Recommendation 14:** *Continue to monitor the plans of the FY2024 SNF VBP and beyond. Continue to drive innovation as many of the measures that have been implemented by the CO P4P are aligned with future CMS initiatives.*