Colorado Department of Health Care Policy and Financing

2023 Nursing Facilities Pay for Performance Application Review

Recommendations Report

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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 2023 (calendar year 2022) Pay for Performance (P4P) program. This Recommendations Report is supplemental to the 2023 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 2023 application included improvements in measures, minimum requirements, and scoring from the previous application period as well as the reintroduction of certain measures removed for the 2022 cycle due to the COVID-19 pandemic and its impact on nursing facilities.

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 2023 application cycle marked the seventh 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 2023 APPLICATION CHANGES

While the third year of the COVID-19 pandemic continued to impact the nursing home population at large, it fortunately had less of a practical impact on the P4P application than 2020, 2021, and 2022. However, persons living in communal settings continue to be at high risk for COVID-19 due to the infectiousness of the disease. Elder adults and those with co-morbidities are at high risk for poor outcomes from COVID-19. Nursing facilities participating in P4P program combine risk factors, serving elder adults or those with co-morbidities in a communal setting, thus making continued prudence essential.

Due to the high-risk nursing home residents faced, nursing homes over the past two application cycles have had to continue infection control procedures to mitigate the risk posed to residents. Infection control procedures affected homes' ability to meet some criteria in the P4P application. For example, quality of life aspects such as dining, personal care, volunteering had to be altered to prevent the spread of COVID-19. The 2021 and 2022 P4P applications were thus modified to accommodate the challenges homes faced with regulatory and operational challenges.

The 2023 application's pre-COVID-19 measures were thus restored to their previous iterations, while still focusing on how the home was transitioning back to "normal" operations. The following changes were made to the 2023 P4P program application.

Prerequisites

- For the resident/family satisfaction survey, homes will now be required to report:
    - The name of the vendor
    - Who is responsible for administering the survey
    - How the survey is administered

Measure 1: Enhanced Dining

- 1.1 – Removed language around adjustments made due to pandemic's regulatory requirements/guidance
- 1.6 – Removed language around adjustments made due to pandemic's regulatory requirements/guidance

Measure 4: Connection and Meaning

- 4.1 – Removed language around promising practices or opportunities that were implemented during the pandemic and then kept in the program

Measure 5: Person-Directed Care Training (CMS, HCPF)

- 5.1 – Removed language around promising practices or opportunities that were implemented during the pandemic and then kept in the program

Measure 6: Trauma - Informed Care (CMS, HCPF)

- There is an additional minimum requirement for the home's initiatives and training related to current trauma experienced in the home such as grief management, coping mechanisms, etc.
    - One point has been added to make this measure now worth 5 points

Measure 8.1: Physical Environment – Appearance

- 8.1.1 – Removed language around impacts of social distancing

Measure 10: Consistent Assignments

- 10.1 – Removed language around promising practices or opportunities that were implemented during the pandemic and then kept in the program

- The points available for this measure have been reduced from 5 points to 4 points

Measure 14: Equity

- New measure with minimum requirements pertaining to evidence of home staff training and initiatives regarding understanding racial and ethnic disparities, ageism/ableism, and gender identity/sexual orientation, as well as their root causes.
- Specifically asks home to provide best practices for shared decision making and implicit bias training.
- There are 2 points available for this measure.

Measure 15: Isolation Protocols

- New measure with narrative-based minimum requirements pertaining to the home's patient-centered efforts and initiatives for patients in isolation protocols, e.g., facilitating communication with families, attending virtual religious ceremonies, maintaining food preferences, and staying physically and mentally active
- There are 2 points available for this measure

Measure 17: Reducing Avoidable Hospitalizations (CMS, HCPF)

- This measure is reinstated and pertains to a home's observed long stay hospitalization data from July 1, 2020 to June 30, 2022 using either Trend Tracker or National Nursing Home Quality Improvement Campaign
- The points available for this measure will be worth three points.

Measure 18: Quality Measures (QM)

- This measure still requires a narrative for a home's three highest percentile QMs, with points awarded on a home's five best scores.
- The points available for this measure have been reduced from 26 points to 21 points.
- The bottom tier (50th percentile and below) has been removed; it is now scored as 1 point for the 40th percentile, 2 points for the 35th percentile, 3 points for the 30th percentile, 4 points for the 25th percentile.

SUMMARY OF 2024 APPLICATION CHANGES

The P4P subcommittee met between September 2022 – May 2023 to discuss adjustments for the 2024 P4P application. The below section describes the committee-approved changes for the upcoming P4P application.

Quality of Life Domain

2023's Measure 9 (QAPI) has been removed. As a result, all 2024 measures after Measure 8 have shifted forward 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. There are 3 points available for this measure.

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 language 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-print materials).
  - Auxiliary aids and 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 remains worth 3 points.

Measure 17: Nationally Reported Quality Measures Scores (CMS)

- Measure 17 is now Nationally Reported Quality Measures Scores (CMS). It was previously Reducing Avoidable Hospitalizations.
- This measure 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 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 & Control (CMS)

- Measure 19 is now Antibiotics Stewardship/Infection Prevention & Control. It was previously Best Practices (CMS).
- 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 - 10 of the CDC Infection Control Assessment and Response Tool.
  - https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html
- It remains worth 5 points.

Measure 20: Medicaid Occupancy Average

- Measure 20 is now Medicaid Occupancy Average. It was previously Antibiotics Stewardship/Infection Prevention & Control.
- The Colorado statewide Medicaid Occupancy Average was updated in May 2023. The new average is 64.73%, decreased from 72.3% in 2022.
- 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 Staff Retention Rate.
- It remains worth 2 points.

Measure 23: Nursing Staff Turnover Rate (CMS)

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

Measure 24: Behavioral Health Care

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

RECOMMENDATIONS FOR APPLICATION MEASURES

Minimum Requirements Specificity and Training

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

Recommendation 1: Continue to emphasize Measure 6's (Trauma Informed Care) minimum requirements 6-2 and 6-3 in trainings and delineate the differences and intentions behind each requirement. Ensure homes understand the macro vs. micro level trauma examples.

As Measure 6: Trauma Informed Care saw its second year in use (it was implemented in 2022), there was an anticipated adjustment period for providers to become familiarized with the minimum requirements' criterion. Additionally, PCG noticed a couple appeals pertaining to the introduction of minimum requirement 6-6, *Provide a narrative describing your home's initiatives and training around current trauma experienced in the home specifically related to:*

- *Grief management, including anticipatory grief*
- *Coping mechanisms*
- *Compassionate care*
- *Managing trauma-related stress*
- *Building resilience in staff and residents*

As is typically the case with newly introduced measures and minimum requirements, some providers did not clearly address each of these components in their narratives.

Additionally, minimum requirements 6-2 and 6-3 were areas for which homes were most frequently not awarded points in the 2022 application cycle. The language of these minimum requirements was adjusted based on prior feedback. Minimum requirement 2 is looking for details on trauma-informed care on the

macro (or home-wide) level and minimum requirement 3 is looking for details on the micro (or resident) level. PCG recommends continuing to focus on these specific minimum requirements in future trainings to ensure homes understanding of the measure's intentions.

Recommendation 2: Clarify measure language of Measure 25 (RAE Contact) by specifying that in order to receive points, the RAE contact must be an individual, not a general phone line or email address.

PCG received a number of appeals for Measure 25: Behavioral Health Care, which requires homes to provide the name and contact information of the individual at the Regional Accountable Entity (RAE) responsible to be the liaison between the nursing home and RAE for behavioral health services. Homes pointed to their lack of having an actual RAE individual contact, and that they often will instead utilize a general phone line or email address to initiative this referral process. Going forward, PCG recommends clarifying this measure's portal language to specify that points cannot be received unless the RAE contact is in fact an individual.

Recommendation 3: Implement a "Document Attachment Verification" step during the Preliminary Review to catch unopenable attachments earlier in the review process.

Two separate homes had accessibility issues with their attached datasets across multiple performance measures. They were both ultimately awarded points back through the appeals process. Successful documentation attachment and document accessibility continue to be perennial pain points in the application submission process. PCG recommends implementing a "Document Attachment Verification" step during the Preliminary Review as an additional Quality Control tool to catch such unopenable attachments or documents with other accessibility issues earlier in the review process.

New Measures

Recommendation 4: Continue to discuss ways to further build a culture of equity within nursing homes in Colorado.

Improving health equity across marginalized resident groups continues to be a critically important goal of the P4P program. Over the past two application cycles, the Department, PCG, and the P4P Sub-committee have brainstormed ways to measure equity within Colorado nursing homes, which resulted in the addition of the Equity measure for the 2023 application. The primary goal of the first year was to collect details on the initiatives that homes have in place around equity, diversity, and inclusion.

The information, research, and data provided below is a summary from the 2022 Recommendations Report. PCG wishes to call attention to this section in this report and provide recommendations on how to further enhance the Equity measure in future years.

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	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 patients 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 of 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?	Provide your home's policies and procedures for evaluating non-English language proficiency (e.g. Spanish proficiency) for caregivers who communicate with patients in languages other than English. Provide a census of the demographic breakdown of your staff. Include a narrative on how your staff reflects the patient community served.
Does the hospital educate all staff responsible for communicating with patients regarding their medical care on interpreter services available within the healthcare system?	Provide your home's policies and procedures for accommodating patients with a primary language other than English.
Does the hospital provide staff-wide education on: i. Racial and ethnic disparities and their root causes? ii. Best practices for shared decision making?	Provide evidence of your home's training on: • Racial and ethnic disparities and their root causes, and • Best practices for shared decision making. Include learning objectives from the training.
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?	Provide evidence of your home's training on implicit bias.
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

HQIP Measure	Nursing Home P4P Recommendation
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 patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect. Provide evidence of communication to patients, 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?	Include in Measure 13: Transitions of Care: Admissions, Transfer and Discharge Rights (CMS, HCPF) Provide four (4) examples of discharge plans that meet patient's health literacy, language, and cultural needs.
Does the hospital have initiatives in place to build a culture of equity, including systems for reporting, response, and learning?	Provide evidence of your home's initiatives to increase equity awareness and sensitivity for residents and staff.
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 patients 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.

HQIP Measure	Nursing Home P4P Recommendation
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.

Dierfelt (2021) examined racial disparities at the end of life, with a focus on how the COVID-19 pandemic has shone an even brighter spotlight on the continuing discrimination that racial minorities face within the medical system.[1] Such findings included:

- Black patients receive more aggressive and nonbeneficial medical care at the end of life. Black people diagnosed with terminal cancer have greater odds of intensive care unit and emergency department admissions, and those with lung cancer are also more likely to undergo mechanical ventilation. Black patients with trauma are more likely to undergo highly invasive procedures and experience physician and systems-based biases compared with White patients with trauma. When addressing end-of-life matters, physicians offer less information about a diagnosis, prognosis, and treatments to Black patients. Failure to share such information can lead to care that is discordant with patient values and late referrals to hospice or palliative care services.
- Hospice use is lower among Black patients than White patients. Spiritual beliefs, cultural systems, and mistrust in the medical system help explain Black patients' preferences for life-sustaining treatments. Inadequate communication from physicians can cause patients to misunderstand hospice services, leading to inappropriate hospice referrals or hospice disenrollment. Difficulties accessing necessary resources may influence hospice use. Black patients are more likely to have difficulty accessing medications; their caregivers are less likely to receive home visits from case providers and aides, even when enrolled in hospice.

Campbell et al (2016) analyzed quality of life deficiencies in nursing homes with low, medium, medium-high, and high concentration of racial/ethnic minority residents.[2] The definitions of low, medium, medium-high, and high concentration can be found below:

Table 2. Minority Resident Concentration and Categorization in Nursing Home Equity Study.

Category	Percent Concentration of Minority Residents
Low	<5%
Medium	5%-15%
Medium-high	15%-35%

[1] American Family Physician, "Racial Disparities at the End of Life"
[2] Sage Journals, "Racial/Ethnic Disparities in Nursing Home Quality of Life Deficiencies, 2001 to 2011"

High	≥35%

Rizzuto and Aldridge (2018) examined racial disparities in hospice outcomes.[3] They reviewed:

- Hospital admissions,
- Emergency department visits, and
- Hospice disenrollment after hospice enrollment.

Estrada, Agarwal and Stone (2021) studied racial and ethnic disparities in end-of-life care, specifically palliative care. They identified Nursing Home health disparities across the following areas: [4]

- Advance care planning
- End-of-life hospitalizations
  Pain management for racial/ethnic minority residents

Li and Cai (2015) used social engagement as the primary measure of demographic disparities.[5] They are used the covariates of:

- Age,
- Gender,
- Marital status,
- Difficulties in activities of daily living,
- Cognitive performance scale score,
- Hearing ability,
- Vision ability,
- Presence of adequate communication abilities, and
- Presence of certain diseases.

Social engagement was measured using a social engagement score developed by Mor et al. (1995).[6] The score is calculated by a six-item social engagement scale using Minimum Data Set (MDS) data. The six items were:

1. At ease interacting with others,
2. At ease doing planned or structured activities,
3. At ease doing self-initiated activities,
4. Able to establish own goals,
5. Able to pursue involvement in life of facility, and
6. Able to accept invitations into most group activities.

Hefele et al. (2017) used eight long-stay quality measures to evaluate demographic disparities in care.[7] The eight measures are:

1. Weight loss,
2. High-risk pressure ulcers,
3. Low-risk pressure ulcers,
4. Incontinence,
5. Depressive symptoms,
6. In restraints daily,
7. Experienced a urinary tract infection, and

[3] Journal of the American Geriatric Society, "Racial Disparities in Hospice Outcomes: A Race or Hospice-Level Effect"
[4] National Library of Medicine, "Racial/Ethnic Disparities in Nursing Home End-of-Life Care: A Systematic Review"
[5] Office Journal of the Medical Care Section, American Public Health Association, "Racial and Ethnic Disparities in Social Engagement Among US Nursing Home Residents"
[6] Oxford Academic, The Journals of Gerontology, "The Structure of Social Engagement among Nursing Home Residents"
[7] ScienceDirect, "Examining Racial and Ethnic Differences in Nursing Home Quality"

8. Urinary tract functional decline.

Recommendation 5: Per CMS's newly proposed COVID-19 vaccination guidelines for staff and residents, consider utilizing resident- and staff-vaccination data to track booster statuses.

Measure 16: Vaccination Data currently captures qualitative data on homes' educational efforts on Pneumococcal, Influenza, and COVID-19 vaccinations for both residents and staff via a narrative. However, given CMS's new FY24 vaccination guidelines for nursing home staff and residents that recommend continuously collecting COVID-19 vaccination data (specifically as it pertains to boosters), it is worth considering the implementation of such quantitative data collection in the Colorado P4P program.

Recommendation 6: Per CMS's FY23 "Minimum Staffing Requirements" initiative, consider expanding data collection from aggregate staffing-resident ratios to also capture qualitative staff satisfaction metrics.

The current P4P application captures baseline aggregate staffing-resident ratio data pertaining to staff retention and length of time in positions. However, to enhance the programmatic snapshot of staff satisfaction, a potential valuable addition is a staff satisfaction-specific survey to capture a more in-depth level understanding of nursing home staff's key retention-centered concerns. This prospective addition would supplement the existing "Staff Engagement" measure (Measure 12).

RECOMMENDATIONS FOR THE APPLICATION PROCESS

Web Portal

As mentioned above, this was the seventh 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 7: Require photographic supporting documentation to be uploaded in specific formats/versions (i.e., PDF) to ensure reviewers' ability to access.

As discussed in Recommendation #3, the 2023 application cycle saw technical issues related to some providers' photographic supporting documentation attachments. There were a number of photo attachments that were uploaded via versions incompatible with the portal, and reviewers were subsequently unable to access the data contained. PCG recommends potentially requiring supporting documentation to be uploaded in a uniform format (e.g., PDF format) to eliminate such accessibility problems.

Recommendation 8: Continue to require homes to upload documentation to each minimum requirement as opposed to tying all the measure's documents to the first minimum requirement or uploading to the wrong minimum requirement.

The submission process also does not specify where homes need to upload documentation. Homes are still able to upload a batch of documentation to the first minimum requirement of a measure and the reviewer would be expected to sift through the file and score the entire measure. This creates issues with the scoring process as it is not always clear how the document pertains to each minimum requirement. Going forward, PCG recommends that the P4P program continue to require homes to upload a file to each minimum requirement, instead of one batch on the measure level, as well as clarifying existing portal language to explicitly instruct uploading supporting documentation to the correct minimum requirement. This will improve both the comprehensive and preliminary review processes as PCG would be able to validate that each minimum requirement has a document associated.

A proposed portal enhancement from one of the providers PCG visited during on-sites is the implementation of a pop-up feature that flags if a home inputs "Yes" in a minimum requirement's self-score but does not

upload a piece of supporting documentation to that same minimum requirement. If a home inputs “No”, no documentation upload is necessary, thus not triggering the pop-up warning. This is an excellent suggestion that PCG’s Development Team and the Department should continue to explore.

Recommendation 9: Continue to explore obtaining CASPER Quality Measure data from an external data source.

In previous years, PCG and the Department have explored the possibility of obtaining home-level CASPER Quality Measure data from an external data source. Homes would no longer need to report this data each year, reducing administrative burden, and improving the scoring process by eliminating manual review. In the 2023 application cycle, there were two separate homes that submitted their quarterly CASPER reports as one combined report, instead of the separate reports for Q3 and Q4, respectively, that the measure requires. While both homes were ultimately awarded back the lost points for this minimum requirement, separate quarterly CASPER reports are optimal for reviewer accessibility and ease of scoring. As this continued to be a data submission pain point for providers this application cycle, PCG recommends the refocused consideration of obtaining this CASPER QM data from an external source instead of homes self-submitting.

Recommendation 10: Move up the date of outreach to external stakeholders for required data (e.g., the annually updated Quality Measures from Telligen and the re-hospitalization data from AHCA and CMS) to ensure sufficient time for data intake and processing.

The current P4P workplan delineates that PCG contacts the necessary external stakeholders for updated data in the May-June timeframe, per the P4P workplan. This data is specifically the annually updated Quality Measures and re-hospitalization rates from Telligen and the American Health Care Association (AHCA), respectively. In the 2023 application cycle, there was an unforeseen delay receiving the re-hospitalization data from AHCA, resulting in an overall delay in finalized scores and per-diem buckets being implemented. To mitigate such delays in the future, PCG recommends the shifting forward of this outreach in the workplan; e.g., contacting our external stakeholders for the required data in March instead of May. The implementation of this recommendation is dependent upon CMS and thus subject to practical constraints. However, the negative impact of late external data on the program’s application review and per-diem bucket finalization timelines makes this change worth exploring.

RECOMMENDATIONS FOR PROGRAM PARTICIPATION

There was a slight increase in program participation between 2022 and 2023:

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

Recommendation 11: Continue to reach out to homes that created an account on the web portal but did not submit an application or reapply for the program. Reach out to first-time participants and engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation. Alternatively, consider engaging these homes through their larger, affiliated organization.

PCG conducted an analysis of participating homes, but no obvious trends or themes emerged beyond a slight increase in program participation. To better understand obstacles hindering those homes who did not submit applications, the Department could distribute a short survey to obtain clear reasons why these nursing facilities did not participate. This may be an opportunity for the Department to expand outreach and consider feedback that would encourage greater participation statewide.

Recommendation 12: Implement a second Provider Portal and Application Changes Training (supplemental to the existing December training) to the application year to maximize the amount of existing and prospective providers reached.

When PCG conducted on-site visits of participating homes in April 2023, one key piece of provider feedback was the request for a second Provider Portal and Application Changes Training to supplement the one PCG holds annually in December. Providers touted the value of this training 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 believes that an additional provider training, staggered strategically around key winter application deadlines, will maximize the amount of existing and prospective nursing home participants reached.

Recommendation 13: Highlight the February 28 application submission deadline and emphasize to providers the value of early document collection and submission versus last minute.

Similar to Recommendation #12, the 2023 application cycle experienced a comparatively heavy 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 highlighting the submission deadline and reinforcing to homes the value of early document collection and submission versus last minute will alleviate this back-loading of end-of-period submissions.

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 (FY) 2019. PAMA includes details about the readmission measures for the program, how facilities will be scored, the performance standards and periods, how facilities can review their scores, and how performance will be reported to the public. The SNF VBP's goal is to support improved clinical outcomes and experiences for skilled nursing facility patients. This program rewards participating skilled nursing facilities based on measures associated with hospital readmissions.

2023 AND 2024 PROGRAM UPDATES

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

- Result in a net increase of 3.7%, approximately $1.2 billion in Medicare Part A payments to SNF's in FY24
  - This estimate reflects $2 billion increase resulting from a 6.1% net market basket update to payment rates; and
  - A 2.3% decrease in FY24 SNF PPS rates because of the second phase of the Payment-driven Payment Model (PDPM) adjustment recalibration.
- Propose 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 being public reporting of four measures.
- Propose the adoption new quality measures beginning in 2025, 2026, and 2027[8]

In April 2022, CMS issued its FY2023 proposed rule for the SNF PPS. The proposed rule would:[9]

- Decrease total SNF payments by $320 million in FY 2023, compared to FY 2022, which includes:

[8] CMS, Fiscal Year (FY) 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1779-P)
[9] Federal Register, DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 42 CFR Part 413

    - An annual payment update of 3.9%, which reflects a market basket increase and other adjustments; and
    - A 4.6% cut to maintain budget neutrality during the first year of the Payment-driven Payment Model (PDPM) case-mix system in FY 2020.
- Beginning in October 2023, resume reporting certain measures and patient data that were delayed due to the impacts of the COVID-19 pandemic.
- Collect stakeholder input on a number of potential future quality measures to address health equity and a future proposed rule around minimum staffing level requirements for nursing.
- Introduce a new quality measure on the rate of influenza vaccination for staff.
- Plan to introduce two new quality measures starting in FYs 2026 and 2027.

Proposed Changes to the Skilled Nursing Facility Quality Reporting Program (SNF QRP)[10]

CMS is proposing the adoption of the **Discharge Function Score (DC Function) measure** beginning with the FY 2025 SNF QRP. This measure assesses functional status by assessing the percentage of SNF 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 is proposing the adoption of the **CoreQ: Short Stay Discharge (CoreQ: SS DC) measure** beginning with the FY 2026 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 is proposing 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 FY 2026 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 is proposing to modify **the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure** beginning with the FY 2025 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 14*: *Continue to monitor the plans of the FY2023 SNF VBP and beyond. Continue to drive innovation via the CO P4P-CMS aligned initiatives.

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

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) is a Directed Payment Program paid out annually by Texas Medicaid. The goal of this program is to encourage nursing facilities to improve the quality of their services.[11] Improvement is measured by several quality measures that are submitted directly by nursing facilities and reviewed by the Centers for Medicare & Medicaid Services (CMS).[12]

The following changes were made to the quality measures for FY2023:

- 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 pursue specific outcomes developed by NF as part of focuses PIP.
- Component 2: Workforce Development Metric 3: NF 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 Five-Star Quality Measures Metric 4: (CMS N024.02) Percent of residents with a urinary tract infection.
  - 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. [13]
- Component 4: Infection Control Program: Metric 1: Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship.

Additionally, HHSC (Texas Health and Human Services) reinstated QIPP reporting requirements and MDS-based quality measures that were waived the previous year due to COVID-19.

OKLAHOMA

In 2019, Oklahoma implemented a PFP program, which replaced 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.[14]

The program uses the following 4 MDS-based quality measures to measure the quality of care:

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,

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[11] U.S. Department of Health and Human Services, Aspects of Texas' Quality Incentive Payment Program Raise Questions About Its Ability To Promote Economy and Efficiency in the Medicaid Program

[12] Texas Health and Human Service, Quality Incentive Payment Program for Nursing Homes

[13] Texas Health and Human Services, Quality Incentive Payment Program (QIPP) Revised Draft Quality Metrics for State Fiscal Year (SFY) 2024

[14] 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:[15]

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.[16]

Proposed rule revisions to remove outdated language and include new language that aligns with federal requirements to the PFP program payment criteria section is pending implementation. A board meeting was held in June 2022 where the new language was reviewed alongside submitted feedback.[17]

MINNESOTA

In 2016, the Minnesota Legislature authorized a new system for nursing facility reimbursement rates, which the Department of Human Services (DHS) calls the value-based reimbursement system. Under the value-based system, DHS sets facility reimbursement rates based on the cost of providing care to residents. 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.[18]

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 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 by 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 attempted to improve and reward nursing facility quality using three main strategies:

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 are state inspections by the Minnesota Department of Health and the third are quality indicators

[15] Oklahoma Health Care Authority, OHCA Policies and Rules
16 Oklahoma Health Care Authority, Pay for Performance training Manual 2023
[17] Oklahoma Health Care Authority, APA WR # 22-10 Pay-for-Performance (PFP) Program
[18] Minnesota House of Representatives, Nursing Facility Reimbursement and Regulation

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
- 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 resident's quality of life and care by decreasing the prevalence of UTIs.
        xi. Improve resident's care outcomes by strengthening primary care engagement, improving hospice integration, and facilitation employee trainings/mentorships.[19]
    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 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

[19] Minnesota Department of Human Services, Performance-based Incentive Payments (PIPP) Project Summaries - FY 2023-2025

improving overall care and satisfaction. Through this initiative facilities are also able to continually compare their performance alongside state and national benchmarks.

The state's largest purchaser of nursing home facilities, 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%, MyInnerView 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.[20]

CALIFORNIA

California's Quality Accountability Supplemental Payment Program (QASP) has been in operation since 2014. The program is also referred to as the Quality Accountability Program for Skilled Nursing Facilities. The California Department of Public Health (CDPH) partners with the California Department of Health Care Services (DHCS) to implement QASP. CDPH's Center for Health Care Quality assesses and scores each facility's quality of care for its residents. Based on these scores the DHCS issues incentive payments to facilities.[21]

As part of Health Services Advisory Group, Inc. (HSAG)'s recent report in August 2021, a 60-day cut-off rule was implemented as part of the QASP program. This 60-Day Rule applies to the assessments in the Minimum Data Set (MDS) 3.0 data and says that assessments submitted more than 60 days after an assessment's target date are excluded from the quarterly and aggregate measure calculations. This rule was put in place by the CDPH and DHCS to encourage Freestanding Skilled Nursing Facilities (SNFs) to submit assessments and any subsequent corrections in a timely manner.[22]

Additionally, CDPH requested that HSAG assess the current data completeness measure methodology and develop an alternative methodology for the data completeness measure that evaluates if expected assessments that qualify as a target assessment (TA) are received for each resident in the expected timeframes.

The 60-Day Rule allows facilities to monitor their rates and payment eligibility status more efficiently on a quarterly basis through the QASP data portal. Because any change in measure rates may affect the payments for all facilities in the QASP program, the 60-day rule ensures that assessments are accurate when they are first submitted.

The percentage of assessments removed due to the 60-Day Rule in Quarter one of 2019-2020 was 2.75%, in Quarter two it was 4.17%, and in Quarter three 3.27%. The 60-Day Rule also affected the number of facilities who were eligible for incentive payments in 2019-2020. Twelve facilities saw an increase in their payment tier while 60 facilities decreased their payment tier.

The Quality Measures currently being assessed are the following:

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[20] Georgia Department of Community Health, Nursing Home Providers

[21] California Department of Public Health Center for Health Care Quality, Skilled Nursing Facility Quality and Accountability Supplemental Payment Program: California-Specific Pressure Ulcer Measure Specifications

[22] California Department of Public Health Center for Health Care Quality, Skilled Nursing Facility Quality and Accountability Supplemental Payment Program: 60-Day Rule and Data Completeness Methodology Overview

- Physical Restraints: Long Stay
- Facility-Acquired Pressure Ulcer Incidence: Long Stay
- Influenza Vaccination: Short Stay
- Pneumococcal Vaccination: Short Stay
- Urinary Tract Infection: Long Stay
- Control of Bowel/Bladder: Long Stay
- Self-Report Pain: Short Stay
- Self-Report Pain: Long Stay
- Need for Help with Activities of Daily Living: Long Stay
- California-specific Received an Antipsychotic Medication: Long Stay
- 30-Day SNF Rehospitalization
- Staff Retention

A Quality Measure for pressure ulcers has been proposed. [23]

NEW YORK

New York has participated in a nursing facility pay for performance program since 2008.[24] Currently, the state's program is referred to as the Nursing Home Quality Initiative (NHQI). NHQI is an annual quality and performance evaluation project that focuses on improving the quality of care for residents in Medicaid-certified nursing facilities across the state of New York.[25]

The current NHQI is based on the previous calendar year's performance. The program was last updated in 2022.

NHQI 2021-2022 Measure Changes			
Measure Name	**2021 Status**	**2022 Status**	**Point Value**
Percent of Long Stay High Risk Residents with Pressure Ulcers	Removed	Brought Back	5 points
Percent of Long Stay Residents Who have Depressive Symptoms	Removed	Brought Back	5 points
Percent of Long Stay Residents Who Lose Too Much Weight	Removed	Brought Back	5 points
Percent of Residents Up to Date with COVID-19 Vaccines with No Medical Contraindications	N/A	New Measure	5 points
Total Nursing Staff Turnover	N/A	New Measure	5 points

[23] California Department of Public Health, Quality Accountability Supplemental Payment Program (QASP)
[24] New York State, Title: Section 86-2.38 - Nursing home incentive payment
[25] New York State, Nursing Home Quality Initiative

In 2022 the NHQI was increased back to a maximum of 100 due to the addition of three quality measures that were previously removed and two new ones, as well as the addition of the efficiency component. These are the list of measures that were added back to NHQI 2022:

1. Percent of Long Stay High Risk Residents with Pressure Ulcers (measure brought back)
2. Percent of Long Stay Residents Who have Depressive Symptoms (measure brought back)
3. Percent of Long Stay Residents Who Lose Too Much Weight (measure brought back)
4. Percent of Residents Up to Date with COVID-19 Vaccines with No Medical Contraindications (new measure)
5. Total Nursing Staff Turnover (new measure)

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. The Quality Component 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)*
3. Percent of Employees Vaccinated for Influenza *(methodology change)*
4. Percent of Long Stay High-Risk Residents with Pressure Ulcers (*measure brought back*)
5. Percent of Long Stay Low-Risk Residents Who Lose Control of Their Bowel or Bladder
6. Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
7. Percent of Long Stay Residents Who Have Depressive Symptoms (*measure brought back*)
8. Percent of Long Stay Residents Who Lose Too Much Weight (*measure brought back*)
9. Percent of Long Stay Residents Who Received the Pneumococcal Vaccine
10. Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
11. Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
12. Percent of Long Stay Residents with Dementia Who Received an Antipsychotic Medication (PQA)
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 *(new measure)*

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.

New York increased its state minimum staffing standard and added a new requirement that facilities spend at least 70% of their total revenue on direct care.[26]

[26] Medicaid and CHIP Payment and Access Commission, Principles for Assessing Medicaid Nursing Facility Payment Policies

UTAH

In Utah, the Nursing Facilities Quality Improvement Incentive (QII) Program 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). All of these components are due before May 31st annually.[27]

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:[28]
    - 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

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.

At the end of 2021, an update was made to the QII program. Code R414-516 was repealed and replaced. This code outlined the CASPER metrics used for the QII program. As part of this change, 5 out of the 9 metrics used previously were kept, while 4 new metrics were included. The 4 new CASPER metrics included by the Utah Health Care Association (UHCA) include the following:

1. Percentage of residents who received an antipsychotic med
2. Percentage of residents who lose too much weight
3. Percentage of residents given the seasonal influenza vaccine
4. Percentage of residents whose ability to move worsened

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.

INDIANA

Indiana's Value Based Purchasing (VBP) program operated by The Centers for Medicare & Medicaid Services (CMS) aims to reward quality and improve health care. Scores to obtain a per diem add on are

[27] Utah Department of Health, NF NSGO QI Program Update (R414-516)
[28] Utah Department of Health, Long-Term Care Resources (NFs and ICFs/ID) QI Incentive Programs

based on survey inspections, staffing, and quality of life measures. Indiana last updated its scoring system in FY20-21. Scoring factors are their weights are:[29]

- 60% determined by long-stay measures from CMS 5-star quality
- 25% determined by the health inspection domain of CMS 5-star
- 10% from staffing domain (PBJ data) of CMS 5-star quality
- 5% for Advanced Care Planning Certification

The Indiana Family & Social Services Administration (FSSA) set the following goals which were used to develop Nursing Facility (NF) rate setting methods that comply with CMS rules.[30]

1. Alignment
2. Sustainability
3. Promote Person-Centeredness and Value-Based Purchasing
4. Reduce Disparities

These goals will be translated into evaluation criteria, to be used for evaluating the current system relative to potential options. Criteria will then be established through a stakeholder process.

The following are the Performance measures to which VBP reimbursements are linked to:

1. Nursing Home Health Survey Score (the maximum quality points awarded in 2020 was 25, compared to 55 points in 2019)
2. Long-Stay Quality Measures (the maximum quality points awarded in 2020 was 60, compared to 30 points in 2019)
3. NF Staff Retention Rate (the maximum quality points awarded in 2020 is 10)
4. Advanced Care Planning (the maximum quality points awarded in 2020 is 5)

The following are additional measures to consider from Stakeholder Feedback Regarding Quality Measures (from February 2021 VBP Meeting):

1. Quality of life
2. Consumer satisfaction
3. Measures aligned with rebalancing such as MDS referrals and low acuity NF residents

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 homes around the state present best practices they developed to improve the quality of care or quality of life for residents.[31]

In 2022 Alabama awarded $40 million of the State Fiscal Recovery Fund from the American Rescue Plan (ARPA) to the Alabama Nursing Home Association. These funds will provide reimbursements to the state's nursing home facilities for the purpose of responding to the COVID-19 pandemic.[32]

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

[29] Leading Age Indiana, Value Based Purchasing
[30] FSSA, Medicaid Nursing Facility Reimbursement Quality and Value Based Purchasing Stakeholder Meeting #1
[31] Alabama Public Health, Nursing Homes
[32] The Office of Alabama Governor Kay Ivey, Governor Ivey Awards Additional $80 Million to Hospitals and Nursing Homes

- 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.[33]

ARIZONA

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a VBP model to financially reward providers. These providers must meet or exceed specific benchmarks to receive payment. Benchmarks are focused on specified quality and cost measures that improve patient's health. Besides improving health outcomes, the VBP model also aims to reduce the overall cost of care for facilities.[34]

AHCCCS VBP encompasses 4 modes of payment to nursing home facilities.[35] These include the following:

1. Alternative Payment Models (APM) reward facilities for providing high quality and cost-efficient care.
2. Differential Adjusted Payments (DAP) provide positive adjustments for providers who achieve designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.
3. Directed Payments are payments provided under managed care contracts between providers and AHCCCS.
4. Performance Based Payments (PBP) are incentive payments to facilities that meet certain performance measure targets.

ACOM's (Administrative, Claims, Financial, and Operational) 306 Policy titled the *Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive* is a manual for how Arizona's nursing home facilities are to measure their Quality Measure Performance (QMP). These QMP scores determine a facility's Combined Performance Score which determines a facility's QMP incentive payments. This manual was put in place between 2017 to 2021.

AHCCCS released their FY23 annual objectives which consisted of the following:

1. Increase the amount of funding the direct care workers providing home and community-based services.
2. Reduce health disparities.
3. Increase available housing and support services.
4. Improve AHCCS member connectivity to critical social services.
5. Finalize roadmap, detailing the modernization of AHCCCS' Medicaid Enterprise System (MES).
6. Improve transparency into delivery system performance.
7. Improve employee engagement.
8. Reduce the amount of time positions remains vacant.[36]

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[33] Alabama Medicaid, Institutional Medicaid: Nursing Home Medicaid Eligibility
[34] AHCCCS, 306 – Alternative Payment Model Initiative – Withhold and Quality Measure Performance Incentive
[35] AHCCCS, AHCCCS Value Based Purchasing (VBP) Strategies
[36] AHCCS, Fiscal Year 2023 Strategic Plan 2-pager

OHIO

In May 2017, Ohio's State Plan Amendment (SPA) 17-004 was approved to provide enhanced payment rates for nursing facilities that provide services to ventilator-dependent individuals. The payment is based on a per-diem payment rate for ventilator-dependent individuals in nursing facilities that participate in the Ohio Department of Medicaid (ODM) nursing facility ventilator program. The per-diem rate equals 60% of the statewide average of the total per Medicaid day payment rate for long-term acute care hospital services for the prior calendar year. The enhanced payment may be reduced by a maximum of 5% if the nursing home's numbers of ventilator associated pneumonia (VAP) episodes exceed the maximum number of VAP episodes determined by ODM for two consecutive quarters. Ohio requires managed care plans to pay the fee for service (FFS) rate, which enables them to pass the enhance payment on to the providers.[37],[38]

In 2020 Ohio suspended the requirement 4.19-D, Supplement 1 of the SPA 17-004. This requirement was to always have a RN with training in basic life support onsite when ventilator weaning services are provided. Facilities now may instead have a respiratory care professional or respiratory therapist with training in basic life support available at the facility.

A one-time payment was made in December 2021 of $300 million in federal funds to COVID-19 relief for Ohio nursing home facilities. A facility's payment amount was calculated by first determining the percentage sufficient to distribute appropriate funds to all facilities across Ohio. Then, this percentage was multiplied by the per Medicaid day payment rate for each facility.[39]

Ohio's Department of Medicaid operates a VBP program called "Episodes of Care".[40] This episode-based payment model seeks to reduce health care costs and improve quality of care by providing transparency on spend and quality across and 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.

The follow episodes are covered by being tied to payments:

- Asthma Exacerbation
- COPD Exacerbation
- Perinatal
- Cholecystectomy
- Colonoscopy
- EGD
- GI bleed
- URI
- UTI

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

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

[37] CMS, Ohio State Plan Amendment (SPA) 17-004
[38] CMS, Ohio State Plan Amendment (SPA) 20-0012
[39] The Ohio House of Representatives, Carruthers Introduces Bill Providing $300 Million to Ohio Nursing Facilities
[40] Ohio Department of Medicaid, Episode-Based Payments

Excellent Alternatives in Kansas, or PEAK. 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. Within the first year of implementation, 125 facilities enrolled in PEAK 2.0.[41] Person-centered care (PCC) intends to improve the quality of life for nursing home residents and residents' clinical health. In a 2018 study titled *Person-Centered Care as Facilitated by Kansas' PEAK 2.0 Medicaid Pay-for-Performance Program and Nursing Home Resident Clinical Outcomes,* it was found that, "…greater PCC adoption through PEAK participation is associated with better quality of care." The report recommended that other states implement Kansas's PEAK model.[42]

The P4P Program in Kansas 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.[43]

In 2023 KDADS released a revision of the program, 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.[44]

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, Colorado's program focuses substantially on measuring residents' quality of life; 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.

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[41] Kansas Department for Aging and Disability Services, PEAK: Quality Improvement Through Person-Centered Care
[42] NCBI, Person-Centered Care as Facilitated by Kansas' Peak 2.0 Medicaid Pay-for-Performance Program and Nursing Home Resident Clinical Outcomes
[43] Medicaid & Maternal & Child Health (MCH) Alignment, Medicaid & Maternal & Child Health (MCH) Alignment: Priorities & Measures
[44] Peak Guidebook, Quality Improvement Through Person-Centered Care 2023-2024

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

CMS under the direction of President Biden's administration launched four new taxpayer-funded initiatives 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:[45]

- ✓ ***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.
- ✓ ***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

[45] The White House Briefing Room, "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes"

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.

In 2023, there were two key updates in federal nursing home policy: CMS's newly proposed regulation requiring more stringent reporting on nursing home ownership and management, and the Biden Administration's $25 billion ARP investment.

- ✓ ***Following the Biden administration's efforts to promote nursing home safety, transparency, accountability, and quality, CMS announced a proposed rule governing nursing home ownership reporting, with a focus on private equity and real estate investment trust ownership.*** *The proposal is an important step in President Biden's initiative to improve the quality and care available at nursing homes. The proposed rule would implement parts of Section 6101(a) of the Affordable Care Act. Requiring nursing homes enrolled in Medicare or Medicaid to disclose additional information regarding owners, operators, and management.*[46]
- ✓ **The Biden-Harris Administration invested $25 billion in ARP funds to help states strengthen their Medicaid home care programs.** Over $9 billion was spent to boost wages for home care workers as well as improve overall job quality.[47] **The President's Budget includes $150 billion over the next decade to improve and expand Medicaid home care services**. This funding would improve the quality of jobs for home care workers and support family caregivers. Administration is also promoting the use of apprenticeship programs and partnering with employers, unions, and others to help recruit, train, and keep long-term care workers at their jobs while also helping advance their careers.[48]

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' 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.[49]

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

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[46] CMS, Biden-Harris Administration Continues Unprecedented Efforts to Increase Transparency of Nursing Home Ownership
[47] Whitehouse.gov, FACT SHEET: Biden-Harris Administration Announces Most Sweeping Set of Executive Actions to Improve Care in History
[48] Whitehouse.gov, FACT SHEET: The President's Budget for Fiscal Year 2024
[49] DHHS, AHRQ's Quality & Patient Safety Programs by Setting: Long-Term Care

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.

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.[50]

Preparing for Emergencies

As of June 2023, 166,715 nursing home residents and 3,111 nursing home staff members have died of COVID-19.[51] 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

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

(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 home owners, 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.

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 range 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 2023 but contains ratings from between 2020 and 2023. 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 2023 P4P Scores

Facility Name	2023 Self Score	2023 Reviewer Score	5-Star Rating
Adara Living	87	85	4
Allison Care Center	80	56	4
Arborview Senior Community	83	80	4
Arvada Care and Rehabilitation Center	84	81	5
Autumn Heights Health Care Center	80	53	2
Avamere Transitional Care and Rehabilitation-Malley	85	82	2
Belmont Lodge Health Care Center	73	65	3
Bent County Healthcare Center	88	77	5
Berkley Manor Care Center	73	67	3
Berthoud Care and Rehabilitation	89	82	3
Beth Israel at Shalom Park	85	83	5
Boulder Canyon Health and Rehabilitation	98	69	3
Briarwood Health Care Center	80	61	4
Brighton Care Center	85	76	4
Broadview Health and Rehabilitation Center	80	65	3
Brookside Inn	95	95	5
Bruce McCandless CO State Veterans Nursing Home	82	81	4
Cambridge Care Center	91	71	4
Castle Peak Senior Life and Rehabilitation	88	65	2
Cedars Healthcare Center	61	61	1
Centre Avenue Health & Rehab	56	50	5
Centura Health- Medalion Health Center	88	79	3
Cheyenne Mountain Center	89	83	2
Christian Living Communities Suites at Someren Glen Care Center	75	68	5
Christopher House Rehabilitation and Care Community	92	84	1
Clear Creek Care Center	91	79	4
Colonial Health and Rehabilitation Center	38	34	1
Colorado State Veterans Nursing Home- Rifle	86	69	4
Colorado Veterans Community Living Center at Homelake	54	54	5
Colorow Care Center	84	78	3
Columbine West Health and Rehab Facility	84	79	4
Cottonwood Care Center	88	85	3
Cottonwood Rehabilitation and Healthcare	91	85	4

Facility Name	2023 Self Score	2023 Reviewer Score	5-Star Rating
Creekside Village Health and Rehabilitation Center	22	22	1
Crestmoor Health and Rehabilitation	88	62	3
Crowley County Nursing Center	83	52	2
Denver North Care Center	81	77	5
Desert Willow Health and Rehabilitation Center	85	72	4
Devonshire Acres	84	77	4
E Dene Moore Care Center	83	63	5
Eagle Ridge of Grand Valley	73	49	2
Eben Ezer Lutheran Care Center	81	76	4
Elevation Health and Rehabilitation Center	93	57	2
Elk Ridge Health and Rehabilitation Center	51	36	3
Englewood Post Acute and Rehabilitation	80	74	4
Evergreen Nursing Home	21	7	5
Fairacres Manor, Inc.	90	84	5
Falcon Heights Health and Rehabilitation Center	76	56	1
Forest Ridge Senior Living, LLC	85	66	4
Forest Street Compassionate Care Center	97	68	4
Fountain View Health and Rehabilitation Center	71	58	3
Good Samaritan Society - Fort Collins Village	46	39	5
Good Samaritan Society- Loveland Village	33	24	2
Harmony Pointe Nursing Center	94	93	4
Highline Rehabilitation and Care Community	92	75	5
Holly Heights Care Center	90	84	5
Holly Nursing Care Center	92	92	2
Horizons Care Center	90	46	3
Irondale Post Acute	93	93	2
Julia Temple Healthcare Center	94	92	5
Junction Creek Health and Rehabilitation Center	71	46	2
Juniper Village- The Spearly Center	88	66	1
Kiowa Hills Health and Rehabilitation Center	42	34	2
La Villa Grande Care Center	42	31	5
Larchwood Inns	82	64	4
Life Care Center of Aurora	72	46	4
Life Care Center of Colorado Springs	38	35	5
Life Care Center of Evergreen	50	50	5
Life Care Center of Greeley	88	70	5
Life Care Center of Littleton	82	68	4
Life Care Center of Longmont	60	27	5
Linden Place Health and Rehabilitation Center	81	72	3
Littleton Care and Rehabilitation Center	93	93	5
Lowry Hills Care and Rehabilitation	83	73	2

Facility Name	2023 Self Score	2023 Reviewer Score	5-Star Rating
Mantey Heights Rehabilitation and Care Center	74	56	2
Mapleton Post-Acute Rehabilitation	27	25	5
Mesa Manor Center	87	80	2
Mesa Vista Healthcare DBA Boulder Post Acute	77	67	2
Mountain Vista Health Center	94	82	3
North Shore Health and Rehab Facility	78	63	4
North Star Rehabilitation and Care Community	78	64	3
Orchard Valley Health and Rehabilitation Center	26	26	4
Park Forest Care Center, Inc.	85	82	2
Parkview Care Center	93	80	3
Pelican Pointe Health and Rehabilitation Center	56	48	3
Pikes Peak Center	86	83	1
Poudre Canyon Health and Rehabilitation Center	73	54	3
Prestige Care Center of Fort Collins	83	46	2
Prestige Care Center of Morrison	92	41	2
Pueblo Center	88	85	1
Regent Park Nursing and Rehabilitation	75	62	5
Rehabilitation and Nursing Center Of The Rockies	90	48	5
Rehabilitation Center at Sandalwood	80	80	4
Ridgeview Post Acute Rehabilitation Center	95	68	1
Rio Grande Rehabilitation and Healthcare Center	90	84	3
River Valley Rehabilitation and Healthcare Center	92	54	2
Riverbend Health and Rehabilitation Center	67	60	2
Rowan Community, Inc	90	80	4
Sierra Rehabilitation and Care Community	85	66	4
South Platte Health and Rehabilitation Center	66	50	4
South Valley Post Acute Rehabilitation	96	89	4
Southeast Colorado Hospital LTC Center	65	50	4
Spanish Peaks Veterans Community Living Center	89	86	5
Spring Village Care Center	45	23	5
St Paul Health Center	80	74	2
Sterling Living Center	73	44	1
Suites at Clermont Park Care Center	88	70	4
Summit Rehabilitation and Care Community	87	87	5
Sundance Skilled Nursing and Rehabilitation	65	65	0
The Green House Homes at Mirasol	82	76	5
The Katherine and Charles Hover Green Houses, Inc.	89	62	4
The Peaks Care Center	56	27	2
The Valley Rehabilitation and Healthcare Center	79	76	5
The Villas at Sunny Acres	82	79	4

Facility Name	2023 Self Score	2023 Reviewer Score	5-Star Rating
Trinidad Rehabilitation and Healthcare Center	95	95	1
University Heights Rehab and Care Community	98	84	1
Uptown Health Care Center	86	33	3
Valley Manor Care Center	91	79	3
Valley View Health Care Center Inc.	88	82	2
Vista Grande Rehabilitation and Health Care	85	52	5
Walsh Healthcare Center	88	61	2
Washington County Nursing Home	75	31	2
Western Hills Health Care Center	84	27	3
Westlake Care Community	83	68	5
Westlake Lodge Health and Rehabilitation Center	64	46	4
Wheatridge Manor Care Center	86	65	4

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	65.0	65	1
1	65.2	22-95	12
2	60.2	24-93	26
3	64.3	27-85	22
4	69.2	26-93	34
5	62.0	7-95	31

RECOMMENDATIONS

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

Recommendation 1: *Continue to emphasize Measure 6's (Trauma Informed Care) minimum requirements 6-2 and 6-3 in trainings and delineate the differences and intentions behind each requirement. Ensure homes understand the macro vs. micro level trauma examples.*

Recommendation 2: *Clarify measure language of Measure 25 (RAE Contact) by specifying that to receive points, the RAE contact must be an individual, not a general phone line or email address.*

Recommendation 3*: Implement a "Document Attachment Verification" step during the Preliminary Review to catch unopenable attachments earlier in the review process.*

Recommendation 4: *Continue to discuss ways to further build a culture of equity within nursing homes in Colorado.*

Recommendation 5: *Per CMS's newly proposed COVID-19 vaccination guidelines for staff and residents, consider utilizing resident- and staff-vaccination data to track booster statuses.*

Recommendation 6: *Per CMS's FY23 "Minimum Staffing Requirements" initiative, consider expanding data collection from aggregate staffing-resident ratios to also capture qualitative staff satisfaction metrics.*

Recommendation 7: *Require photographic supporting documentation to be uploaded in specific formats/versions (i.e., PDF) to ensure reviewers' ability to access.*

Recommendation 8: *Continue to require homes to upload documentation to each minimum requirement as opposed to tying all the measure's documents to the first minimum requirement or uploading to the wrong minimum requirement.*

Recommendation 9: *Continue to explore obtaining CASPER Quality Measure data from an external data source.*

Recommendation 10: *Move up the date of outreach to external stakeholders for required data (e.g., the annually updated Quality Measures from Telligen and the re-hospitalization data from AHCA and CMS) to ensure sufficient time for data intake and processing.*

Recommendation 11*: Continue to reach out to homes that created an account on the web portal but did not submit an application or reapply for the program. Reach out to first-time participants and engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation. Alternatively, consider engaging these homes through their larger, affiliated organization.*

Recommendation 12*: Implement a second Provider Portal and Application Changes Training to the application year to maximize the amount of existing and prospective providers reached.*

Recommendation 13*: Highlight the February 28 application submission deadline and emphasize to providers the value of early document collection and submission versus last minute.*

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: *Continue to emphasize Measure 6's (Trauma Informed Care) minimum requirements 6-2 and 6-3 in trainings and delineate the differences and intentions behind each requirement. Ensure homes understand the macro vs. micro level trauma examples.* ***Recommendation 2:*** *Clarify measure language of Measure 25 (RAE Contact) by specifying that in order to receive points, the RAE contact must be an individual, not a general phone line or email address.* ***Recommendation 3:*** *Implement a "Document Attachment Verification" step during the Preliminary Review to catch unopenable attachments earlier in the review process.* ***Recommendation 4:*** *Continue to discuss ways to further build a culture of equity within nursing homes in Colorado.* ***Recommendation 5:*** *Per CMS's newly proposed COVID-19 vaccination guidelines for staff and residents, consider utilizing resident- and staff-vaccination data to track booster statuses.* ***Recommendation 6:*** *Per CMS's FY23 "Minimum Staffing Requirements" initiative, consider expanding data collection from aggregate staffing-resident ratios to also capture qualitative staff satisfaction metrics.*	***Recommendation 7:*** *Require photographic supporting documentation to be uploaded in specific formats/versions (i.e., PDF) to ensure reviewers' ability to access.* ***Recommendation 8:*** *Continue to require homes to upload documentation to each minimum requirement as opposed to tying all the measure's documents to the first minimum requirement or uploading to the wrong minimum requirement.* ***Recommendation 9:*** *Continue to explore obtaining CASPER Quality Measure data from an external data source.*	***Recommendation 10:*** *Move up the date of outreach to external stakeholders for required data (e.g., the annually updated Quality Measures from Telligen and the re-hospitalization data from AHCA and CMS) to ensure sufficient time for data intake and processing.* ***Recommendation 11:*** *Continue to reach out to homes that created an account on the web portal but did not submit an application or reapply for the program. Reach out to first-time participants and engage these homes through a short survey and follow up as necessary to collect information around barriers and motivations to participation. Alternatively, consider engaging these homes through their larger, affiliated organization.* ***Recommendation 12:*** *Implement a second Provider Portal and Application Changes Training to the application year to maximize the amount of existing and prospective providers reached.* ***Recommendation 13:*** *Highlight the February 28 application submission deadline and emphasize to providers the value of early document collection and submission versus last minute.* **Recommendation 14:** *Continue to monitor the plans of the FY2024 SNF VBP and beyond. Continue to drive innovation as many of the*

Application	Portal	Programmatic
		measures that have been implemented by the CO P4P are aligned with future CMS initiatives.