THE PACIFIC HEALTH POLICY GROUP

OKLAHOMA FOCUS ON EXCELLENCE

Independent Evaluation

Prepared for:
State of Oklahoma
Oklahoma Health Care Authority

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EXECUTIVE SUMMARY

Introduction

In 2008, the Oklahoma Health Care Authority (OHCA) implemented "Focus on Excellence", a voluntary, incentive-based payment and quality reporting system for Medicaid participating nursing facilities. Focus on Excellence assesses participating nursing facilities on a combination of clinical and other quality-related measures and uses the data to establish adjustments to facility base payment rates. Focus on Excellence also publishes facility results on a consumer website, using a 1 – 5 "star" rating system.

The Pacific Health Policy Group (PHPG) was retained by the OHCA to assess the appropriateness of the quality measures and incentive payment structure, as well as the usefulness of the information presented to consumers on the program website. PHPG also compared Focus on Excellence to pay-for-performance systems and consumer websites in other states and at the federal level.

PHPG consultants interviewed the OHCA staff and the outside vendor responsible for operating Focus on Excellence. PHPG also conducted interviews with stakeholders in Oklahoma, to assess their satisfaction with the program and explore opportunities for improvement.

Focus on Excellence Model

The concept for Focus on Excellence traces back to work of the Health and Human Services Interagency Task Force, whose recommendation for a quality component to nursing facility rates was codified in the Oklahoma Medicaid Reform Act of 2006 (HB2842). Focus on Excellence has two components – an incentive payment methodology tied to nursing facility performance against defined quality criteria and a star rating system published on a website accessible to consumers. The program relies on a set of eleven quality-related performance measures:

1. Quality of Life;
2. Resident/Family Satisfaction;
3. Employee Satisfaction;
4. System-wide Culture Change;
5. Certified Nursing Assistant/Nursing Assistant Turnover and Retention;
6. Nurse Turnover and Retention;
7. State Survey Compliance;
8. Clinical Measures;
9. Nursing Staffing per Patient Day;
10. Overall Occupancy (used on website only); and
11. SoonerCare (Medicaid) Occupancy and Medicare Utilization (used in incentive payment methodology only).

The incentive payment system ranks facilities in relationship to each other. Facilities that rank above the 50th percentile (median) on an individual measure receive points that count toward incentive payment dollars. (The methodology for the State Survey Compliance measure differs from the others and is based on the presence or absence of deficiencies.)

Currently, all quality performance measures are equally weighted. Facilities performing at or above the median on two or more of the ten quality measures earn incentive payments that range from $1.10 up to $5.50 for those meeting the performance threshold on all ten measured criteria.

In addition to earning points for reimbursement, facilities receive star-ratings on individual measures and overall performance, again based on relative ranking against all other participating facilities. Star-ratings are posted on the *Focus on Excellence Nursing Home Ratings* website, where consumers are able to compare facilities both on individual and overall star ratings, although the underlying data supporting the ratings is not provided.

Focus on Excellence and other State Models

Focus on Excellence is one of seven nursing facility pay-for-performance systems to come on-line between 2002 and 2008. The other state programs, some of which are mandatory, are in Georgia, Iowa, Kansas, Minnesota, Ohio and Utah.

Each program assesses performance through some combination of *quantitative* indicators such as clinical measures and staffing, and *qualitative* indicators based on reported satisfaction. Although no program encompasses all of the measures, Oklahoma's is one of the most holistic and comprehensive. Notably, Focus on Excellence is the only program to measure satisfaction from three viewpoints – the resident, family and employee.

The majority of programs refer consumers to the CMS Nursing Home Compare website for ratings information on nursing facilities within the state. Of the seven examined, only two have websites that offer consumers information in the form of star-ratings based on quality measures: Minnesota and Oklahoma.

A noteworthy feature of Minnesota's "Nursing Home Report Card" site is that it provides consumers with a description of the factors and methodologies used to generate star-ratings for each quality measure. Consumers are also able to access the survey instrument used by the state to gauge resident satisfaction. Currently, neither the factors used to create star-ratings nor the survey instruments are available on the Focus on Excellence website.

Focus on Excellence and CMS Nursing Home Care

CMS has created a public website, Nursing Home Compare, which allows visitors to examine quality ratings for Medicare/Medicaid participating nursing facilities in any state. CMS does not have a corresponding incentive payment system for Medicare residents, but recently began to pilot test one in four states.

Nursing Home Compare features an overall five-star rating based on facility performance on three measures, each of which has its own associated five-star rating: state health survey inspections, staffing (direct care hours) and quality measures. Focus on Excellence employs a five-star rating based on facility performance on ten measures, three of which – state survey compliance, direct care hours and clinical outcomes – mirror their CMS counterparts.

The star-ratings available to consumers on the Focus on Excellence website are updated slightly more frequently than those posted on the Nursing Home Compare website. Data used to generate the Focus on Excellence star-ratings is obtained monthly or semi-annually depending on the metric being measured (most monthly data is used to produce quarterly updates). Star-ratings on the Nursing Home Compare website are updated either quarterly or annually.

More significantly, Focus on Excellence uses the most recent available information to generate stars, while Nursing Home Compare includes a longer look-back period – up to three years in the case of health inspection surveys. Oklahoma's approach has the advantage of providing the most current snapshot of facility quality, but CMS' methodology reduces the likelihood that an aberrant reporting cycle will obscure a facility's longer standing quality profile.

As a middle ground between these two approaches, Oklahoma could explore retaining the current star methodology, while making previous star ratings available to website users who wish to see them. This approach offers the best of both systems and would be relatively easy to implement.

Not surprisingly, the different methodologies used by Focus on Excellence and Nursing Home Compare have resulted in variation in nursing facility ratings at the individual measure level (e.g., state health inspections versus state survey compliance). On average, Focus on Excellence awards more stars to facilities for each of the three shared measures than does Nursing Home Compare.

However, the overall ratings in Focus on Excellence and Nursing Home Compare substantially overlap. In the summer of 2009, over three-quarters of the 273 facilities with an overall rating on both sites either had the same number of stars or differed by only one star. Only three facilities received five stars from Focus on Excellence and zero stars from Nursing Home Compare; none had the reverse circumstance.

While any variation beyond one or two stars is unhelpful to consumers, the large overlap between the two sites is noteworthy, given their different methodologies. Much of the

difference is likely due to timing, with CMS relying on longer look-back periods and less frequent updates than Oklahoma. Most stakeholders interviewed by PHPG expressed a strong preference for Focus on Excellence due to its emphasis on fresher data and reliance on a larger number of measures.

One opportunity for more closely aligning the two sites may exist in the area of clinical measures, for which CMS relies on the Minimum Data Set (MDS) and Oklahoma on facility self-reporting. Although Oklahoma's data can be more up-to-date, MDS is a recognized standard for clinical reporting. The OHCA should consider using Nursing Home Compare MDS data within Focus on Excellence, thereby bringing the two sites into closer alignment on this one measure, as well as the aggregate rating.

One other notable feature of Nursing Home Compare is the level of information provided on its website. The Nursing Home Compare website enables its users to view the number of survey inspection deficiencies for each facility, rather than simply seeing the number of stars awarded. Nursing Home Compare site-users also are able to see more detailed data on the number of direct care hours each facility provides and the quality measure percentages which take into account aspects of residents' health, physical functioning, mental status and overall well being.

Many stakeholders expressed a desire for this type of information to be made available on the Focus on Excellence website. The OHCA should explore expanding the functionality of the website to allow visitors to access the underlying data driving facility ratings.

Stakeholder Interviews

Stakeholders in Oklahoma generally endorse the concept of providing financial incentives for quality improvement through a system like Focus on Excellence. The program is seen as working in conjunction with another recent reform, variable payment for direct care staff hours, to encourage quality improvement throughout the industry.

Stakeholders also recognize the program is still in an early phase. Many providers spent the first year becoming familiar with reporting requirements and only now are taking steps to improve their ratings and increase their incentive payments.

At the same time, stakeholders have concerns about three aspects of the program: the threshold for earning incentive payments; the transparency of the star rating system; and the integrity of some data collection and reporting processes.

Incentive Payment Threshold

Focus on Excellence began with no Oklahoma-specific data available to establish performance benchmarks in most categories. The OHCA and its program vendor, My InnerView Inc., elected to begin with a relative ranking system, in effect grading on a curve. The OHCA also decided to

distribute incentive payments broadly, using the 50th percentile (median) as the cutoff within every measure but the state survey.

One of the OHCA's goals in selecting this approach was to encourage participation by a majority of the nursing facilities in the state. The strategy worked, as the participation rate stands above 95 percent.

Looking forward, many stakeholders are now eager to see the program hew more closely to its name, by gradually raising the threshold for incentive payment eligibility. About one-half of the stakeholders also favor rewarding facilities that show substantial improvement over time, even if their absolute rating is low.

In addition, many stakeholders believe that one measure – state survey compliance – should serve as a threshold for participation in the incentive payment program and star-rating system. They believe facilities that fail to meet a defined letter grade threshold should be suspended from the program until their deficiencies are addressed.

Similarly, many stakeholders believe that the measures need not be weighted equally. Some, like occupancy, bear a less direct relationship to quality than others, such as quality of life, and should carry a lesser weight. (Occupancy in particular is viewed as problematic because of differences in occupancy levels between urban and rural facilities related to demographics rather than quality.)

PHPG endorses these findings and recommends the OHCA and My InnerView, in collaboration with providers and other stakeholders explore raising the standard for incentive payments, either by increasing the percentile threshold over time (e.g., 10 percent per year for two years) or establishing absolute thresholds for each measure, which again could be raised gradually over time. PHPG also recommends using the state survey compliance standard as a threshold for inclusion in the incentive payment pool and star system.

The OHCA and My InnerView also should consider establishing a second incentive payment tied to improvement in performance. Facilities that fail to meet the new minimum standard, but that show substantial and sustained improvement could be awarded a smaller payment as recognition of their progress. Finally, the OHCA and My InnerView should explore setting different weights for the individual quality measures.

Star System Transparency

The star rating system on the Focus on Excellence website presents summary results (the stars) and brief descriptions of what each measure represents. The majority of stakeholders favor sharing additional information with website visitors regarding the underlying basis for the scores.

While not every consumer will be interested in the detail of the star ratings, having the detail available adds credibility to the system. There also will be some consumers who seek out more information in advance of visiting a nursing facility, even "arming" themselves with the data so they can review it with the administrator.

At a minimum, PHPG recommends making available the most recent state survey, either directly on the website or through a link to the Department of Health. The underlying data for other measures could be provided outright (e.g., occupancy rates) or in summary fashion, if the total amount of data would be overwhelming. For example, global resident/family satisfaction results could be made available, even if all satisfaction survey data is not. Data collection instruments, such as the satisfaction surveys and nursing facility reporting tools, also could be posted on the website for interested visitors.

Data Integrity

My InnerView takes steps to protect the integrity of the data collection and submission process for each of the quality measures. Providers are trained on appropriate procedures and incoming data is examined for anomalous findings that might indicate errors or fraud.

Despite these steps, many stakeholders, including providers, have concerns about the integrity of the process and the potential for results to be skewed by submission of inaccurate information. There is no evidence that more than a small number of providers have submitted erroneous data. However, the perception of problems among stakeholders is widespread and, left unaddressed, could lead to a drop in confidence, and participation, in the program.

PHPG recommends as a general step that the OHCA distribute a letter to participating providers reminding them of the importance of adhering strictly to data collection protocols when submitting information. Facility owners or administrators should be required to sign an attestation acknowledging that intentional misrepresentation of data could be construed as Medicaid fraud, given that the data is directly linked to payments.

PHPG recommends a series of additional steps specific to each measure, to ensure the integrity of the data collection process. The detailed recommendations are outlined in the exhibit at the end of the executive summary and described in greater detail in chapter four of the report. They include, for example, methods to protect the confidentiality of satisfaction survey process and greater involvement in data collection by an independent third party.

It also would be to the program's benefit to provide a regular forum for stakeholders to consult with the OHCA and My InnerView and offer feedback on potential refinements on quality measures, data collection and other system components. The OHCA should consider establishing a standing advisory group consisting of consumers/consumer representatives, providers and agency stakeholders to meet quarterly, or as needed.

Conclusion

Pay-for-performance systems such as Focus on Excellence represent the future for Medicare and Medicaid. Oklahoma is one of a small group of states to create a long term care pay-for-performance model, but with CMS undertaking its own pilot program their growth at the state level is likely to accelerate.

Oklahoma's system stands-out among its state counterparts as being among the most comprehensive in scope. Focus on Excellence also compares favorably to CMS Nursing Home Compare in terms of its comprehensiveness and freshness of data.

Oklahoma is also a leader in seeking to make comparative data available to consumers in a user-friendly format. Only CMS and one other state have attempted anything similar.

The first year of Focus on Excellence was a learning period, as the OHCA used a low threshold in the incentive payment methodology to encourage participation and nursing facilities became accustomed to the data reporting requirements. The high level of provider participation gives the state the necessary leverage to begin raising the threshold for incentive payments. The OHCA can move over time to define "excellence" in a manner that targets payments to high performing facilities while encouraging lower performing facilities to improve.

Concurrent with these refinements, the OHCA and My InnerView should move quickly to ensure the transparency and integrity of the Focus on Excellence data reporting process. A series of simple-to-implement confidence building measures will bolster support for the program and ensure payments are directed to deserving providers.

SUMMARY OF RECOMMENDATIONS

General

- Continue the Focus on Excellence program in its current structure, while making refinements to the incentive payment methodology, website and data collection methods
- Establish an advisory group with consumer, provider and state agency representation, to provide feedback on program performance and recommendations for improvement

Incentive Payment Methodology

- Gradually increase minimum standard for incentive payment, through higher percentiles or introduction of absolute standards above current benchmark
- Explore awarding incentive payments to facilities that demonstrate significant and sustained improvement
- Use state survey results as a threshold metric for determining if facilities should receive incentive payment; suspend facilities falling below the threshold
- Explore establishing differential weights for measures, based on their relative importance as a marker of quality

Star Rating System and Website

- Allow website visitors to see historical star ratings for nursing facilities, in addition to their current ratings
- Make available the most recent state survey document
- Make available data on other measures in complete or summary form
- Make available data collection tools

Data Collection Integrity Steps

- Require providers to sign annual statement affirming their adherence to data collection protocols
- Take steps to strengthen Satisfaction Survey data collection process
    - Re-brand both instruments as OHCA , rather than provider surveys
    - Provide toll-free number for reporting of interference by providers
    - Require staff members to affirm non-interference when assisting residents
    - Use independent third parties to assist in survey data collection at facilities
- Take appropriate measures to ensure integrity of other data collection activities
    - Require regular refresher training of provider data collection staff
    - Perform “outlier” analysis of submitted data in a systemic manner
    - Consider adopting CMS clinical (“quality”) measure in lieu of existing Focus on Excellence measure
    - Consider establishing urban/rural peer groups for calculation of occupancy measure

CHAPTER 1 – INTRODUCTION

Overview

In 2008, the Oklahoma Health Care Authority (OHCA) implemented "Focus on Excellence", a voluntary, incentive-based payment and quality reporting system for Medicaid participating nursing facilities. As described on the agency's website, Focus on Excellence is intended to consolidate and serve three interrelated public and social policy objectives in a single, integrated program: value-based purchasing, provider improvement and consumer information[1].

Focus on Excellence assesses participating nursing facilities on a combination of satisfaction, clinical and other quality-related measures and uses the data to establish adjustments to facility base payment rates. Facilities also receive customized reports with detailed information on their performance across a variety of indicators.

Focus on Excellence publishes facility results on a consumer website, using a 1 – 5 "star" rating system (www.oknursinghomeratings.com). The system is designed to provide consumers with an objective tool for comparing facilities as part of their decision-making process when arranging placement for themselves or a family member. The site is intended to supplement, rather than substitute for, visits to facilities and other traditional methods of weighing placement options.

The OHCA's adoption of a pay-for-performance, or value-based purchasing system places it at the forefront of a growing movement at both the federal and state levels. . Between 2002 and 2008, similar programs were implemented in Georgia, Iowa, Kansas, Minnesota, Ohio and Utah. In 2009, programs were authorized or launched in Colorado, Maryland and Virginia. All share the common objective of using some combination of financial incentives and public disclosure to improve quality of care and resident (patient) quality of life.[2]

In December 2008, CMS launched "Nursing Home Compare", a public reporting site that includes a set of quality ratings for each Medicare/Medicaid participating nursing facility in the nation. In July 2009, CMS implemented a pay-for-performance pilot program called the Nursing Home Value-Based Purchasing Demonstration (NHVBPD). Four states – Arizona, Mississippi, New York and Wisconsin – have been selected to participate in the demonstration.

[1] See www.okhca.org/providers

[2] Richard J. Mollot, Cynthia Rudder & Nasrin Samji, Long Term Care Community Coalition's An Assessment of Pay for Performance for Nursing Homes with Recommendations for Policy Makers (2008).

Focus on Excellence Objectives

The OHCA has defined three primary objectives for Focus on Excellence. They are to:

1. Develop a pay-for performance mechanism that creates incentives for nursing homes to maintain and improve quality of care;

2. Offer consumers useful information about the relative quality of nursing facilities in Oklahoma; and

3. Provide nursing home management with useful information about their facilities relative to other Oklahoma facilities.

These objectives serve as the benchmarks for the evaluation conducted in the summer of 2009 and the conclusions presented in the report.

Program Evaluation Methodology

Focus on Excellence is in it second year of operations. The program is still new, but enough time has passed for findings to be reached regarding its structure and processes. An early evaluation provides an opportunity to make refinements while providers and other stakeholders are becoming acclimated to the system.

The Pacific Health Policy Group (PHPG) was retained in May 2009 to perform an independent evaluation of the program and report findings and recommendations for improvement. PHPG is a national consulting firm specializing in the evaluation and reform of Medicaid and indigent health care programs, including pay-for-performance systems. The firm's professionals have twenty years of experience in the evaluation and design of nursing facility payment methodologies.

PHPG was assisted by Robert Mollica, EdD, a former senior program director of the National Academy for State Health Policy. Dr. Mollica is a nationally-recognized expert on long term care whose previous work includes a study of Oklahoma's long term care services and delivery system. Dr. Mollica consulted with PHPG on the study methodology and reviewed evaluation findings and recommendations.

The evaluation included an assessment of the appropriateness of the quality measures and incentive payment structure now being employed, as well as the usefulness of the information presented to consumers on the program website. PHPG examined pay-for-performance systems and consumer websites in other states and at the federal level, to serve as a comparison to Focus on Excellence.

PHPG consultants interviewed the OHCA staff and the outside vendor responsible for program data collection and analysis and examined data collection tools and methodologies used to determine Focus on Excellence nursing facility ratings. PHPG also conducted interviews with stakeholders in Oklahoma, to assess their satisfaction with the program and explore opportunities for improvement.

Near the conclusion of the evaluation, PHPG was furnished with data on nursing facility performance by the vendor responsible for nursing facility incentive payments and star ratings. PHPG has included the information in chapter two of the evaluation report. While it provides an early insight into the program's impact on nursing facility performance, the data should be interpreted with caution, given that the program is still less than two-years-old.

Report Structure

Chapter two of the report describes the development and implementation of the Focus on Excellence program. The system's methodology is outlined in detail and early quality improvement performance data is provided.

Chapter three examines pay-for-performance models in other states and compares their features to Focus on Excellence.

Chapter four provides an overview of the Medicare Nursing Home Compare system and compares Focus on Excellence to this federal consumer informational tool.

Chapter five discusses findings from PHPG's stakeholder interviews, including perceptions about the efficacy and integrity of the current quality measures and incentive payment methodology.

Chapter six offers a summary conclusion, based on the findings and recommendations presented in the preceding chapters.

CHAPTER 2 – FOCUS ON EXCELLENCE OVERVIEW

Program Development and Implementation

Legislation

The origins of Focus on Excellence trace back to the Health and Human Services Interagency Task Force, a collaborative group with representatives from the major health and social service departments in the state. Members of the task force worked in 2005 on proposals to reform the Medicaid payment system for nursing facilities, which at that time was one of the few remaining in the nation to pay a uniform, or "flat" rate to all providers, regardless of patient case mix or direct care costs.

The task force ultimately made two major recommendations for changing Oklahoma's nursing facility payment methodology: 1) introduce a "variable" component to payment rates tied to direct care staffing; and 2) introduce a quality component to the payment rate through creation of explicit pay-for-performance incentives. Both recommendations were incorporated into broader health reform legislation enacted in 2006.

Under the Oklahoma Medicaid Reform Act of 2006 (HB2842),[3] the legislature directed the OHCA, "in cooperation with the state Department of Health, a statewide organization of the elderly, representatives of the Health and Human Services Interagency Task Force on long-term care and representatives of both statewide associations of nursing facility operators", to develop an incentive reimbursement plan for nursing facilities that would include, but not be limited to the following:

1. Quality of life indicators that relate to total management initiatives;
2. Quality of care indicators;
3. Family and resident satisfaction survey results;
4. State Department of Health survey results;
5. Employee satisfaction survey results;
6. Certified nursing assistant training and education requirements;
7. Patient acuity level;
8. Direct care expenditures;[4] and
9. Other incentives which include, without limitation, participation in quality initiative activities performed and/or recommended by the Oklahoma Foundation for Medical Quality in capital improvements, in-service education of direct staff, and procurement of reasonable amounts of liability insurance.

[3] OK50RHB 2842 (2006) codified at 56 Oklahoma Statutes (O.S.) § 1011.5.
[4] Direct care expenditures pursuant to subparagraph e of paragraph 2 of subsection I of Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

There is dispute between the OHCA and some representatives of other parties named in the legislation regarding the process under which Focus on Excellence was subsequently implemented. A number of stakeholders expressed disappointment at not being adequately consulted by the OHCA on the program's final design or selection of a vendor.

PHPG evaluators took note of these concerns but drew no conclusions, as they were outside of the scope of the evaluation. However PHPG did examine the procurement process that led to selection of the Focus on Excellence vendor, as this influenced the program's final design.

Vendor Procurement Process

The OHCA issued a Request for Information (RFI) in August 2006 to obtain input from prospective bidders related to the development and implementation of Focus on Excellence. Five organizations responded and provided information that helped to inform the development of a formal Request for Proposal (RFP) issued later in the year. The RFP was released under the aegis of the Department of Central Services, the state's purchasing arm.

In the RFP, the OHCA sought to procure the services of a contractor to provide a turnkey solution for development, implementation and management of a tiered nursing facility reimbursement system based on quality measures. The contractor would be responsible for collecting data about nursing facility quality, assigning a quality score for nursing facilities and determining an incentive reimbursement associated with each quality score.

The desired rating system would include ten or more different quality measures[5]. Each measure would be rated independently and aggregated to create a single quality rating. The OHCA intended the quality rating system to provide new and different information for nursing facilities, rather than duplicate an existing system such as the Oklahoma state Department of Health (OSDH) annual survey or CMS Nursing Home Compare. Although the quality measures could include some currently collected and reported data, the OHCA required that the contractor include four or more measures that would rely on new data collection.

Five organizations submitted a complete proposal. An OHCA evaluation team independently assessed each response for compliance with RFP technical requirements. My InnerView, Inc. (My InnerView), a Wisconsin-based applied research company specializing in performance measurement in the long-term health care sector, received the highest overall score (technical + price) and was selected as the contractor. My InnerView was deemed to be the only bidder with the experience, resources and capacity necessary to deliver a turn-key product that would serve the needs of the program.

[5] The measurement areas identified in the RFP are not repeated here but closely match the areas specified in HB2842.

My InnerView proposed to collaborate with the OHCA and stakeholder groups to implement a quality improvement initiative consisting of three subsystems – tiered reimbursement payment calculations, consumer outreach and provider outreach.

Under the terms of the proposal, nursing facilities would be eligible to receive a Medicaid reimbursement premium based on the ratings received on ten quality performance parameters. (The final set of measures, or parameters, are shown on the next page.) To encourage rapid enrollment of facilities, My InnerView recommended that the OHCA implement a 50th percentile performance threshold.

My InnerView also proposed creation of a consumer website that would allow individuals to view details about individual facilities, including their ratings on each of the quality measures. The ratings would be expressed on a one-star (worst performer) to five-star (best performer) scale.

To support nursing facility quality improvement activities, My InnerView further proposed creating a provider-only website where data elements could be updated and facility-specific performance results viewed. Facilities would also be given the option of collecting and reporting data on additional measures.

Program Implementation

In collaboration with the OHCA, My InnerView held meetings around the state to present nursing facilities and other stakeholders with a preview and overview of Focus on Excellence. Nursing facilities with a current Medicaid contract were given the opportunity to enroll in the program, register and establish an account with My InnerView. The OHCA and My InnerView conducted preliminary provider training and completed provider enrollment by spring of 2007. Two hundred and sixty-six (266) nursing facilities out of about 300 who were eligible elected to participate during the first year[6].

My InnerView completed its initial data collection in late 2007 and qualifying nursing facilities received their first incentive payments in January 2008. The consumer website was launched in March 2008.

[6] As of August 2009, the consumer website presents information 289 participating facilities. Another 14 facilities are identified as non-participants, for a participation rate of in excess of 95 percent.

Focus on Excellence Model

All Medicaid-participating nursing facilities in Oklahoma are eligible to participate in Focus on Excellence, although participation is voluntary. Medicare/private pay-only nursing facilities may independently contract with My InnerView to receive quality performance feedback.

Focus on Excellence has two components – an incentive payment methodology tied to nursing facility performance against defined quality criteria and a star rating system published on a website accessible to consumers. Both components rely on the final set of eleven quality measures agreed to by My InnerView and the OHCA during implementation of Focus on Excellence.

Focus on Excellence Measures

The eleven quality, or performance measures are:

1. Quality of Life;
2. Resident/Family Satisfaction;
3. Employee Satisfaction;
4. System-wide Culture Change;
5. Certified Nursing Assistant/Nursing Assistant Turnover and Retention;
6. Nurse Turnover and Retention;
7. State Survey Compliance;
8. Clinical Measures;
9. Nursing Staffing per Patient Day;
10. Overall Occupancy; and
11. SoonerCare (Medicaid) Occupancy and Medicare Utilization.

One of the eleven measures – overall occupancy – is presented on the consumer website but not included in the incentive payment methodology[7]. The other occupancy measure – SoonerCare (Medicaid) occupancy and Medicare utilization – is omitted from the website but included as part of the incentive payment.

Although the terminology is not identical, the final set of measures aligns closely with those identified in the authorizing legislation (HB 2842), the OHCA's Request for Proposal and My InnerView's response. One change from legislation to implementation was the omission of certified nursing assistant training and education requirements; the OHCA instead is addressing

[7] Oklahoma, like many states, applies an "occupancy adjustment" to nursing facilities whose occupancy rate falls below a state-established minimum. The adjustment raises the number of "resident days" to a level equal to the minimum occupancy rate, thereby spreading costs across a larger resident-days base and reducing the facility per diem. Because it already plays a role in payment rates, the OHCA did not want to include overall occupancy in the incentive payment methodology, opting instead for the SoonerCare occupancy and Medicare utilization measure. The OHCA did elect to publish overall occupancy on the website, where it would be more easily understood by consumers.

this objective through funding of a training program at the Oklahoma City campus of Oklahoma State University. Capital improvements and liability insurance coverage also were omitted from the final list of quality measures[8]. At the same time, the final list included several measures, such as turnover and retention rates, not specifically mentioned for in the legislation but consistent with its call for "other incentives" (see Exhibit 2-1 below).

Exhibit 2 -1 – Quality Measures in HB 2842 and Focus on Excellence

HB 2842 Criteria	Focus on Excellence Measure
Quality of life indicators that relate to total management initiatives	• Quality of life • System-wide culture change
Quality of care indicators	• Clinical measures
Family and resident satisfaction survey results	• Resident/family satisfaction
State Department of Health survey results	• State survey compliance
Employee satisfaction survey results	• Employee satisfaction
Certified nursing assistant training and education requirements	*Addressed through funding of OSU-OKC training program*
Direct care expenditures	• Nursing staffing per patient day
Patient acuity level	• Nursing staffing per patient day (indirectly addresses by rewarding facilities for intensity of patient care) • SoonerCare occupancy and Medicare utilization (indirectly addresses by rewarding facilities for skilled nursing days)
Other incentives which include, without limitation, participation in quality initiative activities performed and/or recommended by the Oklahoma Foundation for Medical Quality in capital improvements, in-service education of direct staff, and procurement of reasonable amounts of liability insurance.	• Certified nursing assistant/nursing assistant turnover and retention • Nurse turnover and retention • Overall occupancy

[8] Liability coverage is a problematic standard because of the difficulty nursing facilities encounter in trying to obtain higher levels of coverage. The state of Tennessee recently required health plans in its managed long term care program to accept lower coverage levels from nursing facilities because of the inability of most providers to meet the health plans' usual coverage requirements.

Incentive Payment Methodology

The Focus on Excellence program utilizes a tiered-reimbursement system to award points to participating facilities that meet established threshold requirements in each of the eleven areas except for overall occupancy.

Facility performance on nine of the remaining ten quality measures is converted into an overall performance rating based on the facility's relative standing among all participating providers. If a facility scores above the 50th percentile (median) on an individual measure, it is awarded one incentive point.

The exception is the state survey compliance metric. A facility is awarded one-point for meeting either of two conditions: (1) being citation-free or (2) if a facility has one or more citations, having no deficiency worse than a "D" (in terms of scope and severity) in a care-related area and no deficiency worse than an "E" (in terms of scope and severity) in a non-care related area. Exhibit 2-2 below presents the full deficiency matrix used by surveyors.

*Exhibit 2 -2 – Nursing Facility State Survey Deficiencies**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm that it is not immediate jeopardy	D	E	F
No actual harm with potential for minimal harm	A	B	C

**Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42CFR 483.13 resident behavior and nursing home practices; 42CFR 483.15 quality of life; 42CFR 483.25 quality of care.*

Currently, all quality performance measures are equally weighted. Facilities performing at or above the median on two or more of the ten quality measures earn points that count toward an incentive payment. The incentive payment can range from one percent of the base rate, or $1.10 per resident day, up to five percent of the base rate, or $5.50 per resident day.

Most participating facilities receive at least some level of incentive payment[9]. The total Medicaid per diems paid to nursing homes in the state range from a low of $120.55, for facilities earning no incentive payments and no additional direct care dollars (through the variable portion of the per diem rate) to $136.33, for facilities earning the maximum incentive payment and maximum direct care rate.

It should be noted that many providers view the incentive payment as a "withhold" that they are forced to earn back, rather than any sort of "bonus" for above average performance[10]. Their argument is that, absent the program, the dollars would be included in their base rates. Not coincidentally, nearly all providers consider the payment amount to be important to their ability to cover costs.

Star Methodology

In addition to earning points for reimbursement, facilities receive a star-rating on ten of the eleven measures, again based on relative performance against all other participating facilities. Overall occupancy, which is excluded from the incentive payment methodology, is included as part of the star rating system, while SoonerCare occupancy and Medicare utilization is excluded.

Stars for nine of the ten measures are assigned based on quintile rankings, with the highest 20-percent of scoring facilities receiving five stars for a particular measure and the lowest 20-percent receiving one star. The single exception is again the state survey compliance measure.

Facilities without any citations in their most recent survey receive five stars. For all other facilities, an index is created based on the number and severity of care-related citations. The facilities are grouped into quartiles, with the top 25-percent receiving four stars and the lowest 25-percent receiving one star.

Star-ratings are posted on the *Focus on Excellence Nursing Home Ratings* website (www.oknursinghomeratings.com. Consumers are able to compare facilities both on individual and overall star ratings, although the underlying data supporting the ratings is not provided. Exhibit 2-3 on the next page summarizes the incentive payment and star rating methodologies.

[9] The program initially included a one percent "participation" payment to all facilities. This automatic payment was eliminated after the first year in favor of a pure pay-for-performance methodology.

[10] Some providers also argue that Oklahoma's low base per diem makes it difficult to achieve quality improvement, even when the incentive payment is added. While it is true that Oklahoma has a low per diem relative to most other states, a recent industry study found that, in terms of percent of costs covered, Oklahoma's rate is among the best in the country. This reflects lower average wage costs in Oklahoma as compared to most other states. See: "A Report on Shortfalls in Funding for Medicaid Nursing Home Care", AHCA, October 2008. http://www.ahcancal.org/research_data/funding/Documents/2008%20Medicaid%20Shortfall%20Report.pdf

Exhibit 2 – 3 – Star Rating and Incentive Payment Methodologies

Measures	Star-Rating Assignment	Incentive Payment Point Assignment
1. Quality of life	5 = top 20% 4 = next 20% 3 = next 20% 2 = next 20% 1 = lowest 20%	1 point if score is above 50th percentile
2. Resident/family satisfaction		1 point if score is above 50th percentile
3. Employee satisfaction		1 point if score is above 50th percentile
4. System-wide culture change		1 point if score is above 50th percentile
5. CNA/NA turnover and retention		1 point if score is above 50th percentile
6. Nurse turnover and retention		1 point if score is above 50th percentile
7. State survey compliance score	5 = Deficiency-free survey For remaining facilities, algorithm applied to generate score based on scope and severity of care-related deficiencies. Facilities then arrayed into quartiles based on scores: 4 = top 25% 3 = next 25% 2 = next 25% 1 = lowest 25%	1 point for (1) deficiency-free survey or (2) no care-related deficiencies worse than level D or non-care related deficiencies worse than level E
8. Clinical outcomes	5 = top 20% 4 = next 20% 3 = next 20% 2 = next 20% 1 = lowest 20%	1 point if score is above 50th percentile
9. Nursing care staffing per patient day		1 point if score is above 50th percentile
10. Overall occupancy		No reimbursement points awarded
11. SoonerCare occupancy and Medicare utilization	Not rated	1 point if both criteria are met: (1) Medicaid occupancy greater than 50% and (2) Medicare Part A utilization above 50th percentile (based on ratio of total patient days paid by Medicare Part A to total patient days paid by Medicaid

Individual Measure Detail

My InnerView collects data for the eleven measures through a combination of satisfaction surveys and facility- or OHCA-generated reports. The specific composition and data collection methodology for each measure is described below. Additional information regarding steps taken to ensure the integrity of the data collection process is provided in chapter five.

Quality of Life and Resident/Family Satisfaction

My InnerView uses a single survey instrument to collect data on quality of life and resident/family satisfaction. Surveys are provided to nursing facilities for distribution to all residents in the facility regardless of payer.

Respondents use a four-point Likert scale ("agree strongly"; "agree"; "disagree"; or "disagree strongly") to register their opinions. Residents who are unable to complete the survey themselves can be assisted by a family member or other responsible party, friend, trained volunteer or, if no other option is available, a trained staff member. Family members receive surveys by mail and return them directly to My InnerView using a postage-paid envelope.

The survey instrument was pre-tested in focus groups and subjected to a formal pilot study to verify its reliability and validity before being put into use. The employee survey discussed in the next section was constructed in the same manner.

The survey queries respondents about their satisfaction across four domains, as shown in Exhibit 2 – 4 below. Ten of the items (red font) are used to calculate the facility's quality of life score, while the other fourteen (blue font) are used to calculate the resident/family satisfaction score. Facilities receive detailed reports displaying results by question and comparing their results to all other facilities in the state.

Exhibit 2 –4 - Resident/Family Satisfaction Survey

Resident/Family Satisfaction Survey Domains	
Global Satisfaction • Overall satisfaction • Recommendation to others	**Quality of Service** • Responsiveness of management • Cleanliness of premises • Quality of meals • Quality of laundry services
Quality of Care • Quality of RN/LVN/LPN care • Quality of CNA/NA care • Quality of rehabilitation therapy • Adequate staff to meet needs • Attention to resident grooming • Commitment to family updates • Competency of staff • Care (concern) of staff	**Quality of Life** • Choices/preferences • Respectfulness of staff • Respect for privacy • Resident-to-staff friendships • Resident-to-resident friendships • Meaningfulness of activities • Religious/spiritual activities • Safety of facility • Security of personal belongings • Quality of dining experience

For an individual survey response to be considered valid and included in the facility's quality of life rating, a respondent must answer at least four of the ten questions. For an individual survey response to be included in the resident/family satisfaction rating, a respondent must answer at least five of the fourteen questions.

In addition, the overall combined facility response rate must be at least 30 percent or the facility is excluded from the rating system until the next round of surveys. My InnerView also disqualifies a facility's score if more than 35-percent of all surveys mailed to family members are returned because of a bad address.

Survey responses are averaged across all quality of life items to arrive at an overall facility rating for satisfaction. The process is repeated for resident/family satisfaction.

Employee Satisfaction and System-wide Culture Change

My InnerView also provides nursing facilities with a survey for distribution to employees. The survey addresses both employee satisfaction and the extent to which the facility is engaged in system-wide culture change, defined as the ability to deliver care efficiently and effectively, while focusing on resident choice and resident well being.

The survey queries employees about their satisfaction across five domains, as shown in Exhibit 2 – 5 below and on the following page. Twenty-one of the items (blue font) are used to calculate the facility's employee satisfaction score, while another seventeen (red font) are used to calculate the system-wide culture change measure.

Exhibit 2 – 5 – Employee Satisfaction Survey

<table>
<tr><th colspan="2">Employee Satisfaction Survey Domains</th></tr>
<tr><td>Global Satisfaction
Overall satisfaction
Recommendation for job
Recommendation for care</td><td>Training
Quality of orientation
Quality of in-service education
Quality of resident-related training
Quality of family-related training</td></tr>
<tr><td>Supervisor
Care (concern) of supervisor
Appreciation of supervisor
Communication by supervisor</td><td rowspan="2">Work Environment
Comparison of pay
Safety of workplace
Adequacy of equipment/supplies
Sense of accomplishment
Quality of teamwork
Fairness of evaluations
Respectfulness of staff
Assistance with job stress
Staff-to-staff communication</td></tr>
<tr><td>Management
Attentiveness of management
Care (concern) of management</td></tr>
</table>

Exhibit 2 – 5 – Employee Satisfaction Survey cont'd.

Employee Satisfaction Survey Domains
Culture Change • Environment encourages new ideas • Encouraged to develop new ways to deliver services • Commitment to staff education/training • Use of interdepartmental teams to solve problems • Line staff participation in quality improvement • Job expectations understood by facility teams • Effectiveness of care and services is measured • Quality monitoring system in place • Continuous evaluation of care and services to change future care and services • Use of data to identify what facility is doing well • Use of data to identify problems with service • Continual improvement in use of data • Support for staff career development • Education and training on problem identification and resolution • Commitment to supporting resident-directed care • Encouragement of employee participation in resident-directed care • Commitment to supporting staff development

For a survey response to be considered valid and counted in the satisfaction measure, the employee must answer at least seven of the satisfaction survey items; the minimum number of items for the system-wide culture portion of the survey is five. In addition, the overall combined facility response rate must be at least 30 percent or the facility is excluded from the rating system until the next round of surveys.

Certified Nursing Assistant/Nursing Assistant and Licensed Nurse Turnover and Retention

Staffing stability is considered an important measure of quality on the assumption that satisfied employees (as demonstrated by longer tenure) are better able to form relationships with residents, understand their needs and understand the work practices of the facility. The same methodology is used to calculate the CNA/nursing assistant and licensed nurse turnover and retention scores.

My InnerView defines turnover as the percentage of CNAs/nursing assistants or licensed nurses who have left employment at the facility during the month. Retention is defined as the percentage of current nursing assistants who have been employed by the facility for at least one year.

Facilities self-report their turnover statistics on a monthly basis, following guidelines provided by My InnerView. The data is entered into a secure Quality Profile website. Facility scores for turnover and retention are initially ranked separately and then averaged together to produce an overall average score.

New scores are calculated on a quarterly basis. Any facility failing to provide all three months of data is disqualified for the period in question.

State Survey Compliance

Nursing facilities are routinely subjected to inspections that measure compliance with state and federal regulations. My InnerView's state survey compliance metric is based on regulations that are directly related to the quality of nursing care provided by the facility.

Facilities report on a monthly basis through the My InnerView Quality Profile. However, the information reported does not change unless an annual survey or re-survey has been conducted. Facilities also are required to provide My InnerView with any subsequent survey activity that result in F-tag citations.

Clinical Outcomes

My InnerView defines this measure in terms of the avoidance of undesired outcomes during the preceding quarter in five areas. Specifically:

1. Residents without falls;
2. Residents without acquired catheters;
3. Residents without acquired physical restraints;
4. Residents without unplanned weight loss/gain; and
5. Residents without acquired pressure ulcers.

Nursing facilities record their clinical outcomes monthly in the My InnerView Quality Profile. Using this data, My InnerView ranks each of the five outcomes separately. The scores are then averaged together across all facilities (regardless of patient acuity/case mix) and ranked to calculate an index of the performance of all participating facilities.

New scores are calculated on a quarterly basis. Any facility failing to provide all three months of data is disqualified for the period in question.

Direct Care Staffing Hours (Nursing Staff per Patient Day)

My InnerView obtains data on facility direct care staffing hours from the OHCA on a monthly basis. Facilities submit the data to the OHCA on a mandatory Quality of Care report, which the OHCFA forwards to My InnerView. The same report is used to capture data for calculation of the direct care staffing portion of nursing facility payment rates.

The direct care staffing hours metric is measured as the ratio of staff hours to residents. The number of nurse and nursing assistant hours are combined to create a single score, with each component weighted equally.

The scores are calculated on a quarterly basis. Any facility failing to provide all three months of data is disqualified for the period in question.

Overall Occupancy & /Medicaid Occupancy and Medicare Utilization

The overall occupancy metric is reported by nursing facilities through the Quality Profile. The SoonerCare occupancy and Medicare utilization metric is reported to the OHCA on the quarterly quality of care report and is calculated as the ratio of Medicare Part A days to Medicaid days.

The scores are calculated on a quarterly basis. Any facility failing to provide all three months of data is disqualified for the period in question.

Exhibit 2 – 6 summarizes the data collection sources and methods employed by My InnerView for each measure.

Exhibit 2 – 6 – Data Collection Sources and Methods

Metric	Data Source	Data Collection Method	Frequency of Data Collection[11]
Quality of Life	MIV Resident and Family Satisfaction Survey	Mail Survey	Semi-Annually
Resident/Family Satisfaction	MIV Resident and Family Satisfaction Survey	Mail Survey	Semi-Annually
Employee Satisfaction	MIV Employee Satisfaction Survey	Mail Survey	Semi-Annually

[11] Monthly items are updated on the website by My InnerView on a quarterly basis, with the exception of the state survey, which is updated upon receipt of new survey (inspection) information.

Exhibit 2 – 6 – Data Collection Sources and Methods cont'd.

Metric	Data Source	Data Collection Method	Frequency of Data Collection
System-Wide Culture Change	MIV Employee Satisfaction Survey	Mail Survey	Semi-Annually
CNA/NA Turnover and Retention	Facility Self-Reported Through MIV Quality Profile	Web-Based System	Monthly
Nurse Turnover and Retention	Facility Self-Reported Through MIV Quality Profile	Web-Based System	Monthly
State Survey Compliance	Facility Self-Reported Through MIV Quality Profile	Web-Based System	Monthly
Clinical Measures	Facility Self-Reported Through MIV Quality Profile	Web-Based System	Monthly
Direct Care Hours Per Patient Day	Facility Self-Reported Through MIV Quality Profile	Web-Based System	Monthly
Occupancy and Utilization	Supplied by the OHCA	Web-Based System	Monthly

Data Reporting to the OHCA

My InnerView submits data on individual measures to the OHCA on a regular basis throughout the year. The updates are intended to provide the OHCA with longitudinal data on individual nursing facility and aggregate industry performance.

My InnerView also provides the OHCA with an annual report that analyzes the effectiveness of the additional reimbursement for services on quality improvement; issues and challenges related to provider participation; and recommendations for program improvement.

Data Reported to Consumers (Website)

Launched in March 2008, the Focus on Excellence *Nursing Home Ratings* website serves as one of a variety of resources that residents and their families can use to obtain information on nursing facilities located within the state. Consumers can enter a zip code and distance from that zip code (in miles) to identify all nursing facilities within a given geographic area.

The *Nursing Home Ratings* site posts the Focus on Excellence star-ratings of participating facilities. Visitors to the site can compare facility scores (stars) by individual measure and by

their overall rating, as well as examine marketing materials for those facilities that have chosen to post them. Visitors also can examine a list of facilities that have elected not to participate in the program.

Data Reported to Nursing Facilities

My InnerView provides nursing facilities with a series of reports intended to support ongoing quality improvement efforts. On a quarterly basis, facilities are provided with a report containing their scores for quality performance, including satisfaction, staffing turnover and retention, clinical measures, state survey compliance, utilization and direct care hours. This quarterly report also indicates whether the facility has earned a point toward the incentive payment within each measure.

Initial Quality Improvement Trends

Shortly before publication of this report, My InnerView shared data on nursing facility performance across selected metrics during the program's first eight quarters. The measures for which data was provided include resident/family/employee satisfaction, clinical outcomes and staff turnover/retention.

The data, which is presented below, also will be part of My InnerView's next annual report to the OHCA. Readers are encouraged to review that report for more in-depth interpretation of the results, as well as for data on measures not addressed here.

Readers also are cautioned not to assign undue importance to performance trends at this early stage. Systemic changes may take several years to emerge from the data. Identified trends also must be evaluated taking into consideration exogenous factors (e.g., the direct care portion of the per diem rate) that may have an impact on performance, independent of Focus on Excellence.

Satisfaction Survey Measures

Exhibit 2 – 7 on the following page shows trends for the four measures captured through the resident/family and employee satisfaction surveys. The raw survey data was converted by My InnerView into weighted averages by assigning the following values: Excellent = 100; Good = 66.7; Fair = 33.3; Poor = 0. The values equate to the four-point Likert scale used on the surveys (e.g., "Strongly Agree" equates to "Excellent").

As the exhibit shows, each of these metrics has improved since the baseline evaluation in the fourth quarter of 2007. The upward trend suggests that satisfaction levels are gradually increasing, both among residents/families and employees.

Exhibit 2 – 7 – Satisfaction Survey Trends

Metric	4Q 2007	2Q 2008	4Q 2008	2Q 2008	Change 2007 - 2009
Quality of Life	69.4	71.4	72.9	73.8	+ 3.9
Resident/Family Satisfaction	71.8	73.2	74.4	74.9	+ 3.8
Employee Satisfaction	61.0	64.0	64.0	66.9	+ 5.9
System-Wide Culture Change	65.4	70.0	70.0	72.9	+ 7.5

Data for the remaining metrics have been reported every quarter since program implementation. There is more variability within these metrics, but several demonstrate net improvement since the baseline evaluation in the third quarter of 2007.

Clinical Outcomes

Exhibit 2 – 8 on the following page presents trends for the five clinical outcome measures. Clinical metrics are reported as the average percent of residents in the quarter not experiencing the outcome. Each of the five clinical metrics has demonstrated improvement since the beginning of the program, although the net improvement for catheters, pressure ulcers, and falls was less than one percentage point for each metric.

The remaining two measures showed somewhat greater improvement. Residents without restraints increased from 93.2 percent at the baseline in the third quarter of 2007 to 97.0 percent at the most recent evaluation in the second quarter of 2009. This is a 3.8 percentage point improvement. Over this same period, residents without sudden weight loss/gain went from 92.1 percent to 94.7 percent, a 2.6 percentage point improvement.

Exhibit 2 – 8 – Clinical Outcome Trends

Component	Q3 2007	Q4 2007	Q1 2008	Q2 2008	Q3 2008	Q4 2008	Q1 2009	Q2 2009
Restraints	93.2%	93.4%	94.4%	95.3%	95.9%	96.2%	96.5%	97.0%
Weight Gain/Loss	92.1%	91.7%	93.0%	93.7%	93.7%	94.1%	94.0%	94.7%
Catheters	97.9%	98.1%	98.3%	98.3%	98.4%	98.6%	98.6%	98.6%
Pressure Ulcers	96.4%	96.5%	96.1%	96.7%	96.4%	96.5%	96.7%	96.9%
Falls	82.4%	83.1%	82.9%	83.2%	83.0%	83.2%	83.7%	83.1%

Staffing Measures

The staffing measures also demonstrated improvement over the program's first eight quarters, as shown in Exhibit 2 – 9 on the following page. Turnover rates dropped among both CNA/NA's and RN/LPN's. Average annualized CNA/NA turnover declined from 150 percent at the baseline evaluation to 123 percent. Average annualized RN/LPN turnover also dropped over this time period, decreasing from 79 percent to 60 percent. Both rates are still among the highest in the nation, however.

Retention, measured as the percent of employees who have been working for the company at least one year, did not demonstrate a notable improvement. Both measures remained nearly flat over the eight quarters.

Direct care hours, the ratio of staffing hours to patient days, did improve between the baseline and the most recent evaluation. Average staff hours per patient days increased from 3.35 in the third quarter of 2007 to 3.55 in the second quarter of 2009. This increase is likely attributable in part to the implementation of the direct care portion of the base per diem rate.

Exhibit 2 – 9 – Staffing Trends

Component	Q3 2007	Q4 2007	Q1 2008	Q2 2008	Q3 2008	Q4 2008	Q1 2009	Q2 2009
CNA/NA Turnover	150%	138%	166%	142%	149%	117%	124%	123%
CNA/NA Retention	46%	47%	45%	45%	47%	47%	46%	46%
RN/LPN Turnover	79%	70%	80%	76%	74%	66%	72%	60%
RN/LPN Retention	57%	58%	58%	58%	57%	58%	58%	58%
Direct Care Hours	3.35	3.36	3.38	3.39	3.38	3.43	3.48	3.55

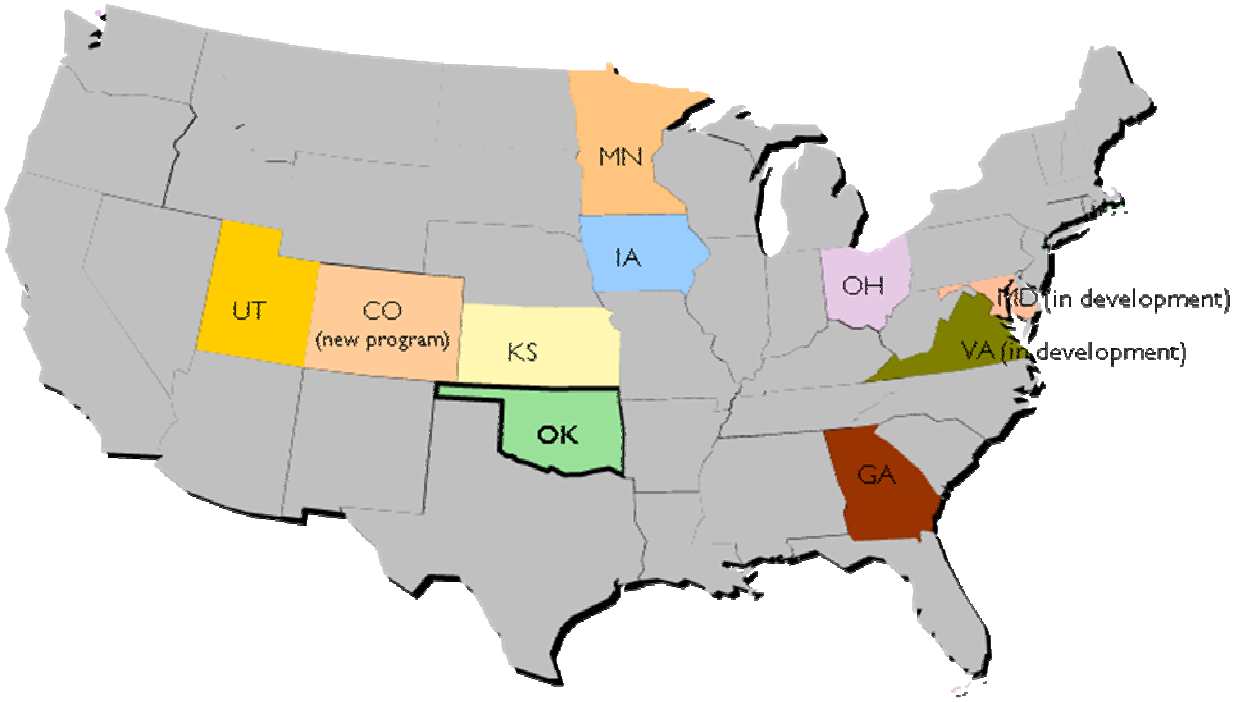
CHAPTER 3 – OTHER STATE MODELS

Oklahoma is one of a growing number of states to implement a nursing facility pay-for-performance system. This chapter presents a brief synopsis of state nursing home pay-for-performance programs that have been in existence for at least one year, as well as the recently launched CMS four-state pilot. Focus on Excellence is then compared to the other programs in terms of comprehensiveness of measures, incentive payment methodology and information for consumers.

The state programs examined include:

- Georgia Nursing Home Quality Initiative
- Iowa Accountability Measures Incentive Program
- Kansas PEAK Program
- Minnesota Quality Add-on Program
- Ohio Quality Incentive Program
- Utah Quality Incentive Improvement Program

Several other states have new programs underway or in development. Colorado launched a pay-for-performance system in early 2009, similar in design to the Minnesota program described later in the chapter. During its 2009 session, the Maryland Legislature enacted a law



requiring the Department of Health and Mental Hygiene to phase in the distribution of revenues to nursing facilities under a pay-for-performance program beginning July 1, 2010. And Virginia is now working on a pay-for-performance program scheduled for implementation later this year.

Program Descriptions

Georgia

The Georgia Department of Community Health, Division of Medical Assistance implemented the Georgia Nursing Home Quality Initiative in 2003, working in collaboration with providers and consumer associations. All nursing facilities within the state are required to participate. The program, which seeks to increase the quality of care received by nursing facility residents, consists of two primary components – targeted training and incentive payments.

My InnerView was selected as the contractor to implement the Georgia system. As in Oklahoma, data collected by My InnerView is analyzed to provide nursing facilities with an opportunity to take action to improve care and satisfaction.[12] In conjunction with annual satisfaction surveys, the collected data also is used by the state to develop targeted nursing facility staff training to address areas perceived as "low quality."

Implemented in 2007, the Georgia Nursing Home Incentive Model, also known as Georgia's Quality Incentive Rate System, provides incentive payments to eligible nursing facilities based on quality indicators. To participate in the program nursing facilities must also participate in the Georgia Nursing Home Quality Initiative and submit monthly data to My InnerView through its Quality Profile website. In addition, facilities must conduct a family satisfaction survey and employee satisfaction survey at least annually.

Facilities receive a one-percent incentive for Nurse Staff Hours/Participation in the Quality Initiative.[13] They also earn points towards Quality Initiative add-on payments[14] by meeting any of the following four non-clinical measures:

- Meet or exceed the state average of 85 percent for responses of either "excellent" or "good" on the question "would you recommend this facility?" on the most current family satisfaction survey score;
- Participate in the Employee Satisfaction Survey;
- Achieve or exceed the quarterly average retention rate for registered nurses, licensed vocational nurses and licensed practical nurses; or
- Achieve or exceed the quarterly average retention rate for certified nursing assistants.

[12] The American Association of Homes & Services for the Aging, state Investment in Culture Change Tool Kit (2008).
[13] Georgia Nursing Home Services Public Notice (May 14, 2009).
[14] In May 2009, the Georgia Department of Community Health, Division of Medical Assistance issued a public notice that effective for services provided on or after July 1, 2009 and subject to payment at fee-for-service rates the Department proposed awarding additional incentive fees paid to nursing facilities who meet specific criteria for quality measures. See Georgia Nursing Home Services Public Notice (May 14, 2009).

Additionally, facilities may earn points for besting the state average in the following six areas of clinical performance, as reported to CMS through Minimum Data Set submissions:

- Percent of high risk long-stay residents who have pressure sores;
- Percent of long-stay residents who were physically restrained;
- Percent of long-stay residents who have moderate to severe pain;
- Percent of short-stay residents who had moderate to severe pain;
- Percent of residents who received influenza vaccine; and
- Percent of low risk long-stay residents who have pressure sores.

For facilities that do not generate enough data to report on the CMS website, the state uses corresponding values obtained from the My InnerView Quality Profile and compares them to the My InnerView Georgia average values.

One point is allocated for each non-clinical and clinical measurement.[15] Nursing facilities that meet a minimum of three points, with at least one point from the clinical measures and one from non-clinical, are eligible for a one-percent add-on to the routine service component of the facility's per diem.[16] For facilities that achieve a minimum of six points, with at least three points obtained from the clinical measures and one from the non-clinical, a two-percent add-on to the routine service component of the facility's per diem is awarded.[17]

Exhibit 3-1 on the following page provides a summary comparison of the Georgia and Oklahoma programs, in terms of performance measure categories and incentive payment amounts. As it shows, Oklahoma has a more comprehensive set of measures and higher a potential incentive payment amount for top performing facilities.

[15] However, only one point is awarded for achieving or exceeding the threshold of either staff stability criteria, and the total points awarded based on staff stability measures will not exceed one. *Id*.
[16] Georgia Nursing Home Services Public Notice (May 14, 2009).
[17] *Id*.

Exhibit 3 – 1 – Comparison of Oklahoma and Georgia Program Features

Measurement Category/*Payment Methodology*	Oklahoma	Georgia
Quality of Life	✓	
Resident/Family Satisfaction	✓	✓
Employee Satisfaction	✓	✓
System-Wide Culture Change	✓	
Staff Turnover and Retention	✓	✓
State Survey Compliance	✓	
Clinical Measures	✓	✓
Direct Care Hours per Patient Day	✓	
Occupancy and/or Utilization	✓	
Other Measures	N/A	None
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative – at/above state average*
Maximum Incentive Payment	*5 percent*	*2 percent*

Iowa

Implemented in 2002, the Iowa Accountability Measures Incentive Program seeks to recognize nursing facilities that provide residents with quality of life and appropriate access to medical assistance in a cost-effective manner. All nursing facilities within the state are required to participate.

The program focuses on four primary areas of quality assurance: (1) quality of patient care, (2) quality of patient life, (3) efficiency and (4) a nursing facility's commitment to care for certain resident populations. To measure quality assurance, the program assesses the following accountability elements:[18]

- Deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations or revisit investigations;
- Regulatory compliance with recertification surveys or for any substantiated complaint investigations;
- Nursing hours at or above the 50th percentile of per resident day nursing hours;

[18] 441 Iowa Admin. Code 81.6 (249A) (2009).

- Resident satisfaction at or above the 50th percentile;
- Resident Advocate Committee resolution rate of issues and grievances at or above 60 percent;
- Occupancy rate at or above 95 percent;
- Maintain employment retention rate at or above the 50th percentile;
- Total administrative costs at or below the 50th percentile;
- Special licensure classification for care of residents with chronic confusion or a dementing illness; and
- Medicaid utilization at or above the 50th percentile.

Points are awarded based on the performance of nursing facilities within the accountability measures. Nursing facilities are eligible for additional Medicaid reimbursement by achieving a minimum score of three points.

Exhibit 3 – 2 below presents the number of points required to receive additional reimbursement.

Exhibit 3 – 2 – Iowa Point System

Number of Points	Amount of Additional Reimbursement
0-2 points	No additional reimbursement
3-4 points	1% of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80%
5-6 points	2% of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80%
7 or more points	3% of the direct care plus non-direct care cost component patient-day-weighted medians multiplied by 80%

Data Source: 441 Iowa Admin. Code 81.6 (249A) (2008).

Any additional Medicaid reimbursement received by a nursing facility is subject to reduction based on the level of citation received for a deficiency.

During its 2009 session, the Iowa Legislature required that changes be made to the accountability measure add-on program, including providing different benchmarks and measures for additional reimbursement based on quality of care. The Department of Human Services convened a work group to develop recommendations and redesign the current program.[19]

[19] Iowa Department of Human Services, Iowa Medicaid Enterprise, Letter to Governor Culver (March 19, 2009).

The work group recommended establishing a system that does all of the following:

- Considers facility regulatory compliance at several times throughout a facility's participation in the program;
- Establishes pre-requisites for program participation; increasing thresholds to achieve points for the various measures;
- Increases the level of the add-on payment to qualifying facilities;
- Establishes static benchmarks; and
- Uses any performance-based payments to support direct care through increased wages, enhanced benefits and expanded training opportunities for facility staff.

As a result of the recommendations, the legislature enacted a law to modify the current program, while renaming it "Nursing Facility Pay for Performance."[20] Performance payments will be based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks in the four domains of: quality of life, quality of care, access for certain residential populations and efficiency.[21]

In addition, the payments cannot exceed five percent of the sum of direct and non-direct care medians, and the increased payments must be included in the calculation of nursing facility modified price-based payment rates, with the exception of Medicare-certified hospital-based nursing facilities, state-operated nursing facilities and special population nursing facilities.[22] The Department of Human Services is in the process of developing the administrative rules to operate the program.[23]

Exhibit 3-3 on the following page provides a summary comparison of the Iowa and Oklahoma programs, in terms of performance measure categories and incentive payment amounts. The Iowa profile reflects the program as it operates today, pending finalization of the redesign and implementation of the legislature's mandated reforms.

[20] Iowa House File 811 §33 (2009).
[21] *Id*. *See also* Iowa Department of Human Services, Iowa Medicaid Enterprise, Informational Letter No. 827 to Iowa Medicaid Certified Nursing Facilities (August 5, 2009).
[22] Iowa House File 811 § 33 (2009).
[23] Correspondence with Jennifer Steenblock, Iowa Long Term Care Program Manager, Bureau of Long Term Care, Iowa Medicaid Enterprise, Iowa Department of Human Services (August 19, 2009).

Exhibit 3 – 3 – Comparison of Oklahoma and Iowa Program Features

Measurement Category/*Payment Methodology*	Oklahoma	Iowa
Quality of Life	✓	
Resident/Family Satisfaction	✓	✓
Employee Satisfaction	✓	
System-Wide Culture Change	✓	
Staff Turnover and Retention	✓	✓
State Survey Compliance	✓	✓
Clinical Measures	✓	
Direct Care Hours per Patient Day	✓	✓
Occupancy and/or Utilization	✓	✓
Other Measures	N/A	Special licensure (dementia unit), Resident advocacy committee resolution rate, Low administrative costs
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative – above 50th percentile*
Maximum Incentive Payment	*5 percent*	*3 percent direct care; Smaller percentage of non-direct care (see narrative)*

Kansas

The Kansas Department on Aging implemented the Promoting Excellent Alternatives in Kansas (PEAK) Nursing Homes initiative in 2002. PEAK serves a dual role by promoting cultural change in nursing facilities through recognition of facilities pursuing progressive models of care and educating providers on how to institute change. Participation in the PEAK program is voluntary.

Implemented in 2007, the Nursing Facility Quality and Efficiency Outcome Incentive Factor is a component of the PEAK initiative and the Kansas Medicaid nursing home rate setting methodology. For state fiscal year 2010, the program provides a monetary incentive for favorable outcomes in the following areas:[24]

[24] Kansas Department on Aging, "Notice of Final Nursing Facility Medicaid Rates for state Fiscal Year 2010: Methodology for Calculating Final Rates & Rate Justification" (2009).

- Case-mix adjusted staffing;
- Staff turnover;
- Completion of the Kansas Culture Change Instrument Survey; and
- Medicaid occupancy.

Points are awarded to nursing facilities that exceed a minimum threshold or demonstrate improvement on these quality outcome measures. Nursing facilities are eligible to receive an incentive payment in their Medicaid per diem rate based on the abovementioned outcomes.

Nursing facilities also must pass a minimum standard on their most recent state survey in order to receive their incentive payment. In order to qualify, a facility must not have received any health survey deficiency of scope and severity level H or higher during the survey review period. Facilities that receive G level deficiencies, but no H level or higher deficiencies, and that correct the G level deficiencies within 30 days of the survey, receive 50 percent of the calculated incentive factor. Facilities that receive no deficiencies higher than scope and severity level F receive 100 percent of the calculated incentive payment.

Exhibit 3 – 4 below presents the outcome measures and requirements and corresponding incentive payment allocation.

Exhibit 3 - 4 – Kansas Measures and Point System

Outcome Measure	Outcome Requirement	Incentive Payment
Case-Mix Adjusted Staffing	(1) Adjusted staffing ration ≥ 75th percentile (4.72); or	$1.00
	(2) Adjusted staffing < 75th percentile but improved by ≥ 10%	$0.10
Staff Turnover	(1) Staff turnover rate ≤ 75th percentile (38%); or	$1.00
	(2) Staff turnover rate > 75th percentile but reduced by ≥ 10%	$0.10
Kansas Culture Change Instrument Survey	Completion of the full survey	$0.15
Medicaid Occupancy	Medicaid occupancy ≥ 60%	$0.45
	Maximum Per Diem Add-on Available	$2.60[25]

Data Source: Kansas Department on Aging, "Notice of Final Nursing Facility Medicaid Rates for state Fiscal Year 2010: Methodology for Calculating Final Rates & Rate Justification" (2009).

Exhibit 3-5 on the following page provides a summary comparison of the Oklahoma and Kansas programs, in terms of performance measure categories and incentive payment amounts. As it

[25]Maximum is capped at less than the sum of the individual components.

shows, Oklahoma has a more comprehensive set of measures and higher a potential incentive payment amount for top performing facilities. However, facilities in Kansas have the opportunity to earn payments by demonstrating improvement, as well as by meeting the standard performance benchmark.

Exhibit 3 – 5 – Comparison of Oklahoma and Kansas Program Features

Measurement Category/*Payment Methodology*	Oklahoma	Kansas
Quality of Life	✓	
Resident/Family Satisfaction	✓	
Employee Satisfaction	✓	
System-Wide Culture Change	✓	✓
Staff Turnover and Retention	✓	✓
State Survey Compliance	✓	Used as threshold to determine eligibility for payment
Clinical Measures	✓	
Direct Care Hours per Patient Day	✓	
Occupancy and/or Utilization	✓	✓
Other Measures	N/A	None
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative – above 75th percentile OR 10 percent improvement*
Maximum Incentive Payment	*5 percent*	*$2.60*

Minnesota

Since 2006, Minnesota has developed several nursing facility quality performance programs, including its Quality Add-On program. The Quality Add-On program provides nursing facilities with an opportunity to receive an adjustment to payment rates in the domains of staffing, quality and survey measures.

During the 2006 rate year, [26] facilities received quality scores in the following areas:

- Minnesota risk-adjusted clinical quality indicators;

[26] The 2006 Rate Year was from October 1, 2006 through September 30, 2007.

- Direct care staff turnover;
- Direct care staff retention;
- Temporary staff usage; and
- State inspection findings.

Exhibit 3 – 6 displays the maximum points awarded for each measure in 2006. Facilities could begin to accrue points at the tenth percentile of all nursing homes and would reach the maximum point values at the 80th percentile. Minnesota applied different weights to the measures, with Clinical Quality Indicators receiving the highest weight and Temporary Staff Usage and State Inspection Findings the lowest.

Exhibit 3 – 6 – Minnesota Point System

Measure	Maximum Number of Points	
	2006	2007
Minnesota risk-adjusted clinical quality indicators	40	35
Direct care staff turnover	15	10
Direct care staff retention	25	20
Temporary staff usage	10	5
State inspection findings	10	10
Resident quality of life	---	20

Data Source: Teresa Lewis, Nursing Facility Rates and Policy, Minnesota Department of Human Services (August 7, 2009).

Facilities receiving scores between 40 and 100 were eligible to receive an add-on of up to 2.4 percent of the operating payment rate in 2006. The median add-on amount per day was $1.23 and the median total add-on revenue for participating facilities during the 2006 rate year was $25,005[27].

During the 2007 rate year, [28] the program incorporated a resident quality of life component. The state contracted with Vital Research to conduct interviews of nursing facility residents in each participating home. Interview topics included comfort, environmental adaptations, privacy, dignity, spiritual well-being, meaningful activity, food enjoyment, autonomy, individuality, security, relationships and mood.

Exhibit 3 – 6 displays the maximum points awarded for each measurement during the 2007 rate year. Facilities receiving scores between 40 and 100 were eligible to receive an add-on of up to

[27] Correspondence with Teresa Lewis, Nursing Facility Rates and Policy, Minnesota Department of Human Services (August 7, 2009).
[28] The 2007 Rate Year was from October 1, 2007 through September 30, 2008.

0.3 percent of the operating payment rate. The median add-on amount per day was $0.15 and the median total add-on revenue for participating facilities was $3,581.

As of August 2009, the Minnesota Legislature has not approved any subsequent quality add-ons to the state's Medicaid payment rates. However, Minnesota has implemented a nursing facility performance-based incentive payment program that allows facilities to earn Medical Assistance payments of up to five percent of the operating payment rate. Facilities submit proposals to implement programs that seek to improve quality and efficiency and contribute to the re-balancing of the state's long-term care system.

Exhibit 3 – 7 below provides a summary comparison of the Oklahoma and Minnesota programs, in terms of performance measure categories and incentive payment amounts. The Minnesota profile reflects program features in place in 2007. As noted above, Minnesota is now inviting performance improvement proposals from nursing facilities as part of the state's broader efforts to rebalance services between institutional and home- and community-based settings.

Exhibit 3 – 7 – Comparison of Oklahoma and Minnesota Program Features

Measurement Category/*Payment Methodology*	**Oklahoma**	**Minnesota**
Quality of Life	✓	✓
Resident/Family Satisfaction	✓	
Employee Satisfaction	✓	
System-Wide Culture Change	✓	
Staff Turnover and Retention	✓	✓
State Survey Compliance	✓	✓
Clinical Measures	✓	✓
Direct Care Hours per Patient Day	✓	✓
Occupancy and/or Utilization	✓	
Other Measures	N/A	None
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative - 10th to 80th percentile (weighted point system)*
Maximum Incentive Payment	*5 percent*	*0.3 percent*

Ohio

The Ohio Department of Jobs and Family Services administers the state's nursing facility Quality Incentive Payment program. Implemented in state fiscal year 2007, this program provides add-on payments to Medicaid-participating nursing facilities that meet specific performance benchmarks.

Points are awarded to each facility based on the following criteria:

- Deficiency free on the most recent standard survey results;
- Resident satisfaction survey results are above the statewide average;
- Family satisfaction survey results are above the statewide average;
- Number of hours nurses are employed is above the statewide average;
- Employee retention rate is above the average for the facility's peer group;
- Occupancy rate is above the statewide average;
- Medicaid utilization rate is above the statewide average; and
- Annual case-mix score is above the statewide average.

For state fiscal year 2010, the average quality incentive payment is $3.03 per diem.[29]

Exhibit 3 – 8 on the following page provides a summary comparison of the Oklahoma and Ohio programs, in terms of performance measure categories and incentive payment amounts. As it shows, Oklahoma has a more comprehensive set of measures, although Ohio's system includes two that are unique to its program.

[29] Interview with Josh Anderson, Ohio Department of Jobs and Family Services, Bureau of Long Term Care (July 22, 2009).

Exhibit 3 – 8 – Comparison of Oklahoma and Ohio Program Features

Measurement Category/*Payment Methodology*	Oklahoma	Ohio
Quality of Life	✓	
Resident/Family Satisfaction	✓	✓
Employee Satisfaction	✓	
System-Wide Culture Change	✓	
Staff Turnover and Retention	✓	✓
State Survey Compliance	✓	✓
Clinical Measures	✓	
Direct Care Hours per Patient Day	✓	
Occupancy and/or Utilization	✓	✓
Other Measures	N/A	Hours of employed nurses; Case mix score
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative – above state average*
Maximum Incentive Payment	*5 percent*	*$3.03 (average payment)*

Utah

Implemented in 2004, the Utah Quality Improvement Incentive program provides Medicaid-participating nursing facilities with an opportunity to receive reimbursement for voluntarily engaging in quality improvement activities.

In previous years, the Utah program has focused on improvement efforts rather than requiring facilities to achieve a specific level of performance to receive payment. However, the state anticipates implementing next year a requirement that facilities demonstrate both improvement and performance ratings comparable to at least average within the state.[30]

[30] Correspondence with John Bromberger, Utah Medicaid Reimbursement Unit (July 21, 2009).

Interested nursing facilities are required to apply for the program annually. For payment consideration, facilities must demonstrate the following quality improvement activities:[31]

- Have a meaningful quality improvement plan that involves residents and family;
- Provide a demonstrated process for assessing and measuring a quality improvement plan;
- Contract an independent third-party group to conduct customer satisfaction surveys in each quarter of the incentive period;
- Create an action plan to address survey items rated below average for the year;
- Develop a plan for culture change and provide an example of how the facility has implemented culture change;
- Establish an employee satisfaction program; and
- Possess no violations that reach an "immediate jeopardy" level at the most recent re-certification survey and during the incentive period.

In state fiscal year 2009, nursing facilities were also offered an opportunity to apply for three new quality improvement incentive opportunities:

- Enhance or purchase nurse call systems;
- Purchase new patient lift systems capable of lifting patients weighing up to 400 pounds each; and
- Purchase new patient bathing systems.

By completing all quality improvement incentive programs, a nursing facility has the opportunity to earn an additional $4.94 per patient per diem during state fiscal year 2010.[32]

Exhibit 3 – 9 on the following page provides a summary comparison of the Oklahoma and Utah programs, in terms of performance measure categories and incentive payment amounts. As with most of the other states, Oklahoma uses a more comprehensive set of measures than Utah. However, Utah encourages performance improvement in specific areas of importance to the state by rewarding facilities that act on these priorities each year.

[31] Utah Admin. Code R414-504-4 (2009).
[32] Correspondence with John Bromberger, Utah Medicaid Reimbursement Unit (July 21, 2009).

Exhibit 3 – 9 – Comparison of Oklahoma and Utah Program Features

Measurement Category/*Payment Methodology*	Oklahoma	Utah
Quality of Life	✓	✓
Resident/Family Satisfaction	✓	
Employee Satisfaction	✓	✓
System-Wide Culture Change	✓	✓
Staff Turnover and Retention	✓	
State Survey Compliance	✓	✓
Clinical Measures	✓	
Direct Care Hours per Patient Day	✓	
Occupancy and/or Utilization	✓	
Other Measures	N/A	Nurse call system; 400lb. patient lift system; new patient bathing system
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Submission of QI plans*
Maximum Incentive Payment	*5 percent*	*$4.94*

CMS Multi-State Demonstration

In July 2009, CMS implemented a pay-for-performance pilot program called the Nursing Home Value-Based Purchasing Demonstration (NHVBPD). Four states have been selected to host the demonstration: Arizona, Mississippi, New York and Wisconsin.

Participating nursing facilities will be provided with financial incentives for demonstrating certain high standards for providing quality care or demonstrating improvement over time in the domains of staffing, appropriate hospitalizations, outcome measures from the Minimum Data Set and survey deficiencies. The threshold for qualifying for an incentive payment will be the 80th percentile of all facilities, in terms of absolute performance or degree of improvement.

The payment pool for each host-state will be determined based on Medicare savings that result from reductions in Medicare expenditures, primarily from reductions in hospitalizations. Through this demonstration, CMS anticipates improving quality by reducing avoidable hospitalizations and subsequent nursing facility stays.

Exhibit 3 – 10 below provides a summary comparison of the Oklahoma and CMS pilot programs, in terms of performance measure categories and incentive payment amounts. The CMS measures align almost exactly with the Nursing Home Compare website components described in chapter four. The only exception is the hospitalization measure, which is being tested in the pilot but is not a feature of the website. Overall, Oklahoma relies on a more comprehensive set of criteria than does CMS.

Exhibit 3 – 10 – Comparison of Oklahoma and CMS Pilot Program Features

Measurement Category/*Payment Methodology*	**Oklahoma**	**CMS Pilot**
Quality of Life	✓	
Resident/Family Satisfaction	✓	
Employee Satisfaction	✓	
System-Wide Culture Change	✓	
Staff Turnover and Retention	✓	
State Survey Compliance	✓	✓
Clinical Measures	✓	✓
Direct Care Hours per Patient Day	✓	✓
Occupancy and/or Utilization	✓	
Other Measures	N/A	Avoidable hospitalizations
Primary Incentive Payment Methodology	*Relative – above 50th percentile*	*Relative – 80th percentile*
Maximum Incentive Payment	*5 percent*	*TBD (funded through savings)*

How Does Focus on Excellence Compare?

Pay-for-Performance Measures

Exhibit 3 – 11 below and on the following page summarizes the quality measure domains and specific indicators being used by pay-for-performance programs across the country. Exhibit 3 – 12 on the second following page compares the measures used in each state and the CMS demonstration as part of their pay-for-performance methodology.

Each program assesses performance through some combination of *quantitative* indicators such as clinical measures and staffing, and *qualitative* indicators based on reported satisfaction. Although no program encompasses all of the measures, Oklahoma's is one of the most holistic and comprehensive. Notably, Focus on Excellence is the only program to measure satisfaction from three viewpoints – the resident, family and employee.

Oklahoma's broader set of measures addresses one of the common criticisms made of pay-for-performance systems: that they encourage providers to concentrate their efforts in the handful of areas being measured at the expense of other quality-related activities. Focus on Excellence avoids this potential downside as well or better than any of the other state programs.

Exhibit 3 – 11 – Measures Currently in Use in One or More States

Measure Domain	Measurement Indicators
Staffing	Employee Satisfaction
	Staff Turnover
	Staff Retention
	Temporary Staffing Agency Use
	Direct Care Hours
Consumer Satisfaction	Family Satisfaction
	Resident Satisfaction
State Survey Compliance	Deficiency-Free Survey
	Corrective Action/Improvement
Resident Quality of Life	Resident Advocate Committee
	Quality Improvement Plan/Program
	Enhanced/New Medical Equipment

Exhibit 3 – 11 – Measures Currently in Use in One or More States cont'd.

Measure Domain	Measurement Indicators
Clinical Measures	Minimum Data Set (MDS) Quality Indicators
	Accidents
	Prevalence of Falls
	Behavior/Emotional Patterns
	Clinical Management
	Cognitive Patterns/Delirium
	Elimination/Incontinence
	Unnecessary Catheterization
	Functional Status
	Residents requiring ADL assistance
	Mobility
	Infection Control
	Nutrition/Eating
	Nutritional Support
	Pain Management
	Residents with Moderate to Severe Pain
	Physical Functioning
	Psychotropic Drug Use
	Quality of Life
	Use of Physical Restraints
	Skin Care
	Prevalence of Pressure Sores/Ulcers
	Post Acute Care
	Short-stay Residents with Moderate to Severe Pain
	Short-Stay Residents with Pressure Sores/Ulcers
	Program Specific Indicators
	Resident Influenza Vaccination
	Hospitalization rate
Facility Efficiency	Occupancy
	Medicare Utilization
	Administrative Costs
	Case-Mix
System-Wide Cultural Change (Resident-Centered Models of Care)	Culture Change Survey
	Culture Change Plan/Program

Exhibit 3 – 12 – Measures by Program

	Pay-for-Performance Programs							
	Oklahoma	Georgia	Iowa	Kansas	Minnesota	Ohio	Utah	CMS Pilot
Program Features	Focus on Excellence	Nursing Home Quality Initiative	Nursing Facilities Accountability Measures Program	PEAK	Quality Add-On Program	Quality Incentive Payment for Nursing Facilities	Nursing Home Quality Improvement Initiative	Nursing Home Value-Based Purchasing Demonstration
Program Start Date	2007	2003	2002	2005	2006	2007	2004	2009
Program Measures								
Quality of Life	✓				✓		✓	
Resident Satisfaction	✓		✓			✓		
Family Satisfaction	✓	✓				✓		
Employee Satisfaction	✓	✓					✓	
System-Wide Cultural Change	✓			✓			✓	
Staff Turnover and Retention	✓	✓	✓	✓	✓	✓		
Survey Deficiencies	✓		✓	✓	✓	✓	✓	✓
Clinical Measures	✓	✓			✓			✓
Direct Care Hours	✓		✓		✓			✓
Occupancy	✓		✓	✓		✓		
Utilization Rates	✓		✓			✓		
Special Licensure			✓					
Case-Mix Score				✓		✓		
Quality Improvement Plan							✓	
Resident Advocate Committee			✓					
Administrative Costs			✓					
Hospitalizations								✓
Payment Incentives								
Flat Per Diem Add-On Bonus				✓	✓	✓	✓	TBD
Percentage of Medicaid Rate	✓	✓	✓					

Consumer Information (State Programs)

The majority of state programs refer consumers to the CMS Nursing Home Compare website for ratings information on nursing facilities within the state. Of the seven examined, only two have websites that offer consumers information in the form of star-ratings based on quality measures: Minnesota and Oklahoma.

As with Focus on Excellence, Minnesota's Nursing Home Report Card seeks to provide information to help consumers choose a nursing home while promoting a high standard of quality in all nursing facilities across the state. Both websites enable consumers to view nursing homes by entering a zip code and distance from that zip code (in miles) to identify all nursing facilities within a given geographic area.

The report card shows how Medicaid-certified nursing facilities rate on seven quality measures, some of which also are part of the pay-for-performance structure last used in 2007. Like Focus on Excellence, each quality measure is scored on a five-star scale, with one star representing the lowest possible rating and five stars representing the highest possible rating. Exhibit 3 – 13 below displays the quality measures reported on Minnesota's Nursing Home Report Card website.

Exhibit 3 – 13 – Minnesota Nursing Home Report Card

Star-Ranked Measures	Measurement Descriptions
Resident Satisfaction/Quality of Life	• Resident satisfaction and quality of life interviews conducted in all nursing facilities • Interviews conducted by an independent contractor • Interview topics include comfort, environmental adaptations, privacy, dignity, spiritual well-being, meaningful activity, food enjoyment, autonomy, individuality, security, relationships and mood
Minnesota Quality Indicators	• 23 MDS quality indicators are used to calculate the quality indicator score from the following groups: psychosocial, quality of life, continence, infections, accidents, nutrition, pain, skin care, psychotropics and functioning • Adjusted to account for differences between nursing homes and types of residents served
Hours of Direct Care	• Refers to the level of staffing that is provided on average in the facility • Facility average direct care hours per resident day are based on annual statistics provided by the nursing facility • Direct care hours include all staff providing direct care to residents, e.g., nurses, social workers and activity staff • Staffing hours per resident day are weighted for relative cost per staff type and adjusted for the facility's average case mix

Exhibit 3 – 13 – Minnesota Nursing Home Report Card cont'd.

Star-Ranked Measures	Measurement Descriptions
Staff Retention	• Refers to how many of the nursing staff and other direct care employees remain employed at the facility for more than one year • Calculation is based on the number of direct are employees on October 1st of one year that are still employed on September 30th of the following year divided by the number of direct care employees
Temporary Staffing Agency Use	• Refers to how much a facility utilizes temporary staff hired from an outside staffing agency in place of staff permanently on their payroll
Proportion of Single Rooms	• Reports the proportion of all beds in the facility in single rooms
State Inspection Results	• The state inspection measure is based on the following 5 criteria: 1. If the facility's most-recent available health and life-safety code survey had actual harm, substandard quality of care or immediate jeopardy 2. If the facility had a confirmed complaint or facility self-report of actual harm, substandard quality of care or immediate jeopardy over the past year 3. If the facility's prior health survey had substandard quality of care or immediate jeopardy 4. If the facility is on the special focus list of providers judged by the Department of Health and CMS as needing additional oversight If the facility has a high number of health deficiencies

Minnesota awards stars based on relative rankings. The mean (average) facility value is identified for each measure, along with the standard deviation from the mean. Facilities then are rated as follows:

- Five stars – Mean plus 1 ½ standard deviations or greater
- Four stars – Mean plus ½ to 1 ½ standard deviations
- Three stars – Mean plus or minus ½ standard deviation
- Two stars – Mean minus ½ to 1 ½ standard deviations
- One star – Mean minus 1 ½ standard deviations or greater

A noteworthy feature of Minnesota's Nursing Home Report Card site is that it provides consumers with a description of the factors and methodologies used to generate star-ratings for each quality measure. Consumers are also able to access the survey instrument used by the state to gauge resident satisfaction. Currently, neither the factors used to create star-ratings nor the survey instruments are available on the Focus on Excellence website.

The Minnesota Department of Health and Department of Human Services anticipates enhancing the website in the near future. The Department plans to include additional and more up-to-date quality measures and to redesign the site based on consumer feedback.

Data for the Focus on Excellence website is collected more frequently than data for Nursing Home Report Card. Focus on Excellence information is obtained monthly or semi-annually depending on the metric being measured. Nursing Home Report Card data is collected on a quarterly or annual basis.

Exhibit 3 – 14 on the next page compares the information available and the data collection and rating methodologies for the Focus on Excellence and Nursing Home Report Card websites.

Exhibit 3 – 14 – Minnesota and Oklahoma Website Features

	Oklahoma Focus on Excellence		Minnesota Nursing Home Report Card	
Quality Measures/Rating Methodology	**Star-Ratings Available to Consumers**	**Frequency of Data Collection[33]**	**Star-Ratings Available to Consumers**	**Frequency of Data Collection**
Resident Quality of Life	✓	Semi-Annually	✓	Annually
Resident/Family Satisfaction	✓	Semi-Annually		
Employee Satisfaction	✓	Semi-Annually		
System-Wide Cultural Changes	✓	Semi-Annually		
Staff Turnover and Retention	✓	Monthly	✓ (retention only)	Annually
Temporary Staffing Agency Use			✓	Annually
Clinical Measures/Quality Indicators	✓ (Clinical Measures)	Monthly	✓ (Quality Indicators)	Quarterly
Direct Care Hours	✓	Monthly	✓	Annually
Occupancy	✓	Monthly		
Proportion of Single Rooms			✓	Quarterly
State Survey Compliance	✓	Monthly	✓	Quarterly
Rating Methodology	*Relative ranking based on quintiles, except for State Survey Compliance, which uses absolute standard for f5 stars and quartiles for 1 – 4 stars*		*Relative ranking based on mean (average) facility and number of standard deviations from the mean*	

[33] Monthly submissions are used to generate quarterly updates to the Focus on Excellence website except for State Survey Compliance, which is updated when new survey results for a facility become available.

CHAPTER 4 – CMS NURSING HOME COMPARE

The Centers for Medicare and Medicaid Services (CMS) created the public reporting site Nursing Home Compare[34] to provide nursing facility residents and their families with an easy to understand assessment of nursing home quality. Facilities that participate in Medicare and/or Medicaid receive a set of quality star-ratings. The system features an overall five-star rating based on facility performance on three types of performance measures, each of which has its own associated five-star rating:[35]

- Health Inspections
- Staffing
- Quality Measures

A score of five stars means that a facility is "much above average", compared to others in the same state. Facilities that receive one star are rated as "much below average" as compared to others in the same state. The specific data collection and reporting methodology employed by Medicare for each measurement area is described briefly below.

Health Inspections

Data Collection

Nursing facilities in all states are required to participate in an onsite comprehensive survey annually, with no more than 15 months elapsing between surveys for any one particular home. Surveys are unannounced and conducted by a team of state health care professionals who assess whether the nursing home is in compliance with federal requirements. Nursing homes are assessed in various quality performance areas including, but not limited to, resident needs, facility administration and staffing, environment, and resident rights and quality of life.

Data Reporting

The Nursing Home Compare health inspection score is calculated based on points assigned to deficiencies identified in each active nursing facility's current health inspection survey and the two prior surveys. The score also incorporates any deficiency findings from the most recent three years of complaints' information and survey revisits needed to verify that corrections

[34] The CMS Nursing Home Compare site is located at www.medicare.gov/NHCompare.
[35] The Centers for Medicare and Medicaid Services, "Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide" (2009).

have brought the facility back into compliance. In calculating the total score, recent surveys are weighted more heavily than earlier surveys.[36]

With respect to health inspection results, points are assigned to individual health deficiencies according to their scope and severity. More points are assigned for more serious, widespread deficiencies. Less serious, isolated deficiencies receive fewer points. Additional points may also be assigned if the deficiency generates a finding of substandard quality of care.

CMS does not assign points for the first survey revisit. However, points are assigned for facilities that require second, third or fourth survey revisits to confirm that correction of deficiencies have restored compliance.

To control for variations that may result from how states manage surveys, license facilities and administer their Medicaid programs, CMS' Five-Star quality ratings on the health inspection domain are based on the relative performance of facilities within a state. Exhibit 4 - 1 illustrates the criteria used to determine facility health inspection ratings.

Exhibit 4 – 1 – Nursing Home Compare Facility Health Inspection Rating Criteria

Criteria	Star-Rating
Top 10% in each state (lowest 10% in terms of health inspection deficiency score)	5-stars
Middle 70% in each state ~89.9-66.6% ~66.6-43.3% ~43.3-20.0%	4-stars 3-stars 2-stars
Bottom 20% in each state	1-star

Data Source: CMS Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (2009).

[36] The most recent surveys are assigned a weighting factor of 1/2, the next most previous period has a weighting factor of 1/3, and the second prior survey has a weighting factor of 1/6.
Complaint surveys are also assigned weighted factor depending on time of occurrence. Surveys that occurred within the most recent 12 months receive a weighting factor of 1/2, those from 13-24 months ago have a weighing factor of 1/3 and those from 25-36 months ago have a weighing factor of 1/6.
Deficiencies that appear on complaint surveys that are conducted within 15 days of a standard survey are counted only once.
For facilities missing data for one period, the health inspection score is determined based on the period for which data are available. The missing survey weight is distributed proportionately to the existing two surveys. *Id*.

Staffing

Data Collection

To determine the star-rating for staffing, CMS looks at the number of hours of care, on average, provided to each resident each day by the facility. The rating for staffing is based on two case-mix adjusted measures:

- Registered nurse hours per resident day
- Total nursing hours per resident day

Registered nurse hours include work performed by registered nurses, registered nurse director of nursing and nurses with administrative duties. Total nursing hours include the hours of registered nurses, licensed practical/licensed vocational nurses, certified nurse aides in training and medication aides/technicians. These staffing measures are derived from the CMS Online Survey and Certification Reporting (OSCAR) system. The measures are case-mix adjusted based on the Resource Utilization Group (RUG-III) case-mix system to account for differences in the level of need of care of residents in different nursing facilities.

Data Reporting

Both staffing measures are given equal weight. For each staffing category, a one to five star-rating is assigned using a combination of percentiles based on the distribution for freestanding facilities and staffing thresholds identified in a CMS staffing study. Exhibit 4 – 2 presents the staffing hours and their corresponding star-ratings.

Exhibit 4 -2 – Nursing Home Compare Staffing Hours Rating Criteria

RN Staffing Ratings and Hours			Total Staffing Ratings and Hours					
			1	2	3	4	5	Total Staffing Rating
			< 2.998	≥ 2.998 - < 3.376	≥ 3.376 - < 3.842	≥ 3.842 - < 4.080	≥ 4.080	Total Staffing Hours*
RN Rating	RN Hours*	RN Hours (percentile ranking)	< 25th percentile	≥ 25th percentile - < median	≥ median - < 75th percentile	≥ 75th percentile - < 4.08	≥ 4.08	Total Staffing Hours (percentile ranking)
1	< 0.221	< 25th percentile	1-star	1-star	2-stars	2-stars	3-stars	
2	≥ 0.221 - < 0.298	≥ 25th percentile - < median	1-star	2-stars	3-stars	3-stars	4-stars	
3	≥ 0.298 - < 0.402	≥ median - < 75th percentile	2-stars	3-stars	4-stars	4-stars	4-stars	
4	≥ 0.402 - < 0.550	≥ 75th percentile - < 0.55 hours	2-stars	3-stars	4-stars	4-stars	4-stars	
5	≥ 0.550	≥ 0.55 hours	3-stars	4-stars	4-stars	4-stars	5-stars	

* Hours have been adjusted per resident day

Data Source: CMS Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (2009).

Quality Measure

Data Collection

CMS rates facilities on quality based on performance against ten clinical measures reported through Minimum Data Set (MDS) filings. CMS selected these indicators based on their validity and reliability and perceived capacity to measure the quality of care being provided in nursing facilities. Depending on the availability of assessments, CMS applies long-stay and short-stay quality indicators for scoring:

Long-Stay Residents

- Percent of residents whose need for help with daily activities has increased
- Percent of residents whose ability to move in and around their room got worse
- Percent of high risk residents with pressure sores
- Percent of residents who had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with urinary tract infection
- Percent of residents who have moderate to severe pain

Short-Stay Residents

- Percent of residents with pressure ulcers (sores)
- Percent of residents who had moderate to severe pain
- Percent of residents with delirium

Data Reporting

To calculate ratings for the quality measure domain, CMS uses the three most recent quarters for which data are available. A summary quality measure score is computed for each facility. The five-star quality measure rating is then assigned based on the nationwide distribution of these scores.

Exhibit 4 – 3 on the following page illustrates the criteria used to determine facility quality (clinical) ratings.

Exhibit 4 -3 – Nursing Home Compare Quality Rating Criteria

Criteria	Star Quality Rating
Top 10% (lowest 10% in terms quality measure deficiency score)	5-stars
Middle 70% ~89.9-66.6% ~66.6-43.3% ~43.3-20.0%	4-stars 3-stars 2-stars
Bottom 20%	1-star

Data Source: CMS Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide (2009).

Overall Score Computation

Facilities receive an overall star-rating based on their individual Health Inspection, Direct Care staffing and MDS Quality measure scores. The composite score is calculated as follows:

Step 1: CMS begins with the Health Inspection five-star rating.

Step 2: If the facility received a star-rating of four or five for Staffing and this score is greater than the Health Inspection rating, CMS adds one star to Step 1. However, if the Staffing rating is one star, CMS subtracts one star from Step 1. The overall rating cannot be more than five stars or less than one star.

Step 3: If the facility received five stars for its Quality Measure rating, CMS adds one star to Step 2. However, if the facility received a measure rating of one-star for its Quality Measure rating, then CMS subtracts one star from Step 2. The overall rating cannot be more than five stars or less than one star.

Step 4: If the facility received one star for its Health Inspection rating, then the Overall Quality rating cannot be upgraded by more than one star based on the Staffing and Quality Measure ratings.

Step 5: If the facility is a "Special Focus Facility[37]" that has not graduated, the maximum Overall Quality rating is three stars.

[37] SFF is a designation imposed by CMS on facilities with a history of serious quality issues, as identified through the health inspection process.

How Does Focus on Excellence Compare?

Quality Performance Measures

Although both systems use a star rating scheme, Focus on Excellence employs a broader array of measures than Nursing Home Compare. Most notably, Focus on Excellence incorporates resident, family and employee satisfaction ratings in awarding quality stars.

Because of its greater number of measures, Focus on Excellence also weights each measure less heavily as a percentage of the whole. The application of equal weights in Focus on Excellence results in an especially wide gap between the two systems on the state survey (inspection) measure. Whereas Oklahoma treats this measure as worth one-tenth of the total weight, CMS uses it as an anchor rating which can only be adjusted incrementally upward or downward based on results in other categories.

The relative merits of the two systems are open to debate. However, none of the programs, state or federal, have existed long enough to be considered "mature". In such an environment, using a larger number of measures reduces the risk that any one faulty measure will bias results and reduce the efficacy of the system. And, as noted earlier, Oklahoma's relatively broad scope avoids the risk that facilities will concentrate their efforts in a few quality-related areas at the expense of others.

Data Collection Methodologies

The star-ratings available to consumers on the Focus on Excellence website are updated slightly more frequently than those posted on the Nursing Home Compare website. Data used to generate the Focus on Excellence star-ratings is obtained monthly or semi-annually depending on the metric being measured (most monthly data is used to produce quarterly updates) . Star-ratings on the Nursing Home Compare website are updated either quarterly or annually.

More significantly, Focus on Excellence uses the most recent available information to generate stars, while Nursing Home Compare includes a longer look-back period – up to three years in the case of health inspection surveys. Oklahoma's approach has the advantage of providing the most current snapshot of facility quality, but CMS' methodology reduces the likelihood that an aberrant reporting cycle will obscure a facility's longer standing quality profile.

In discussions with My InnerView, the vendor suggested that Oklahoma consider retaining the current star methodology, but make previous star ratings available to website users who wish to see them. This approach offers the best of both systems and should be pursued.

Exhibit 4 – 4 on the following page compares the information available and the frequency of data collection for the two websites.

Exhibit 4 – 4 – Oklahoma and CMS Performance Measures

	Oklahoma Focus on Excellence		CMS Nursing Home Compare	
Star-Rated Quality Performance Measures	**Data Source**	**Frequency of Data Collection**[38]	**Data Source**	**Frequency of Data Collection**
Quality of Life	Resident Satisfaction Survey	Semi-annually		
	Family Satisfaction Survey	Semi-annually		
Resident Satisfaction	Resident Satisfaction Survey	Semi-annually		
Family Satisfaction	Family Satisfaction Survey	Semi-annually		
Employee Satisfaction	Employee Satisfaction Survey	Semi-annually		
System-Wide Culture Change	Employee Satisfaction Survey	Semi-annually		
CNA/NA Retention and Turnover	Facility Self-Reports	Monthly		
Nurse Retention and Turnover	Facility Self-Reports	Monthly		
Clinical Measures (Quality Measures for CMS)				
MDS/Clinical Measures				
Accidents	Facility Self-Reports	Monthly		
Elimination/Incontinence	Facility Self-Reports	Monthly	Facility Self-Reports	Quarterly
Infection Control			Facility Self-Reports	Quarterly
Nutrition/Eating	Facility Self-Reports	Monthly		
Pain Management			Facility Self-Reports	Quarterly
Physical Functioning			Facility Self-Reports	Quarterly
Quality of Life	Facility Self-Reports	Monthly	Facility Self-Reports	Quarterly
Skin Care	Facility Self-Reports	Monthly	Facility Self-Reports	Quarterly
Post-Acute Care			Facility Self-Reports	Quarterly
State Health Inspection Compliance	State Health Inspection Survey	Monthly	State Health Inspection Survey	Annually
Direct Care Hours (Staffing for CMS)	Facility Self-Reports	Monthly	Total Nursing Hours Per Resident Day (CMS-671 from OSCAR)	Annually
			RN Hours Per Resident Day (CMS-671 from OSCAR)	Annually
			Resident Census and Conditions (CMS-672 from OSCAR)	Annually
Occupancy	Data from OHCA	Monthly		
Utilization	Data from OHCA	Monthly		

[38]FOE monthly data is updated quarterly on the website, except for state surveys. State survey information changes only when a new survey or re-survey has been conducted

Star-Rated Facilities

CMS Nursing Home Compare features an overall five-star rating based on facility performance on three measures, each of which has its own associated five-star rating: state health survey inspections, staffing (direct care hours) and quality measures. Focus on Excellence employs a five-star rating based on facility performance on ten measures, three of which – state survey compliance, direct care hours and clinical outcomes – mirror their CMS counterparts. The similarities and differences between the three corresponding measures are described below.

State Survey Compliance

Focus on Excellence generates ratings for this measure based on the results of the facility's most recent state survey, whereas Nursing Home Compare incorporates up to three years worth of findings. And under Focus on Excellence, facilities provide information to My InnerView on a monthly basis, including new survey-related data. Nursing Home Compare collects state survey information on an annual basis.

Nursing Home Compare and Focus on Excellence both rate facilities on the scope and severity of survey deficiencies, as well as their relative performance compared to all providers in the state. However, the methodologies are not identical.

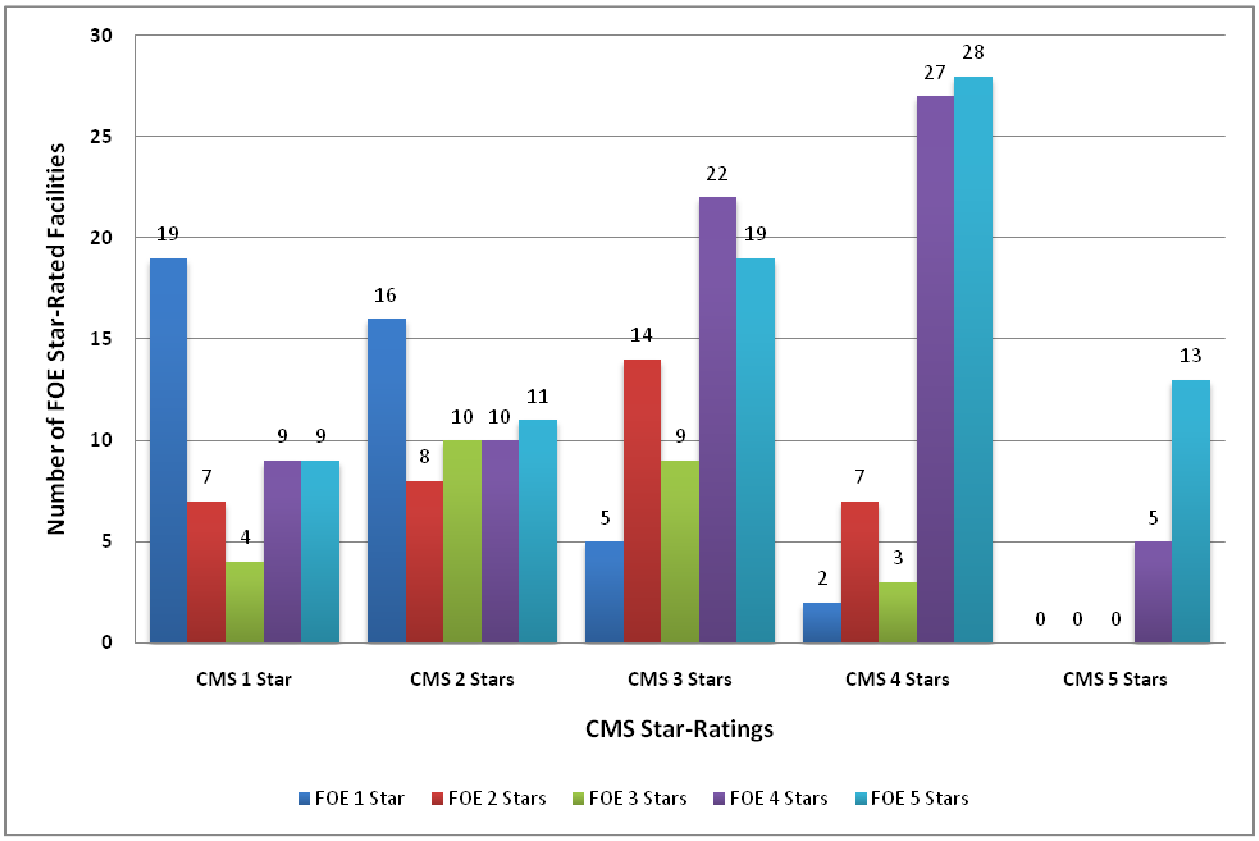
Focus on Excellence awards five stars to any facility without a care-related citation on its most recent state survey while Nursing Home Compare awards five stars to the top ten percent of facilities in the state. Both programs allocate one to four stars based on relative performance.

PHPG tested the impact of the differing methodologies by comparing the most current star ratings (one through five) on the two web sites for the 257 facilities appearing on both. Exhibit 4 – 5 on the next page presents the results.

As the exhibit illustrates, the methodology used by Focus on Excellence generates higher average ratings. Focus on Excellence shows 80 five-star facilities, versus only 18 for Nursing Home Compare. The average rating on the Focus on Excellence website is 3.44, as contrasted with 2.81 on the CMS site.

The difference is unsurprising, since CMS restricts the number of potential five-star facilities and Oklahoma does not. Oklahoma's approach is arguably fairer, since it allows any facility without a care-related deficiency to be recognized as belonging in the top tier.

Exhibit 4 – 5 – State Survey Compliance Rating Comparison



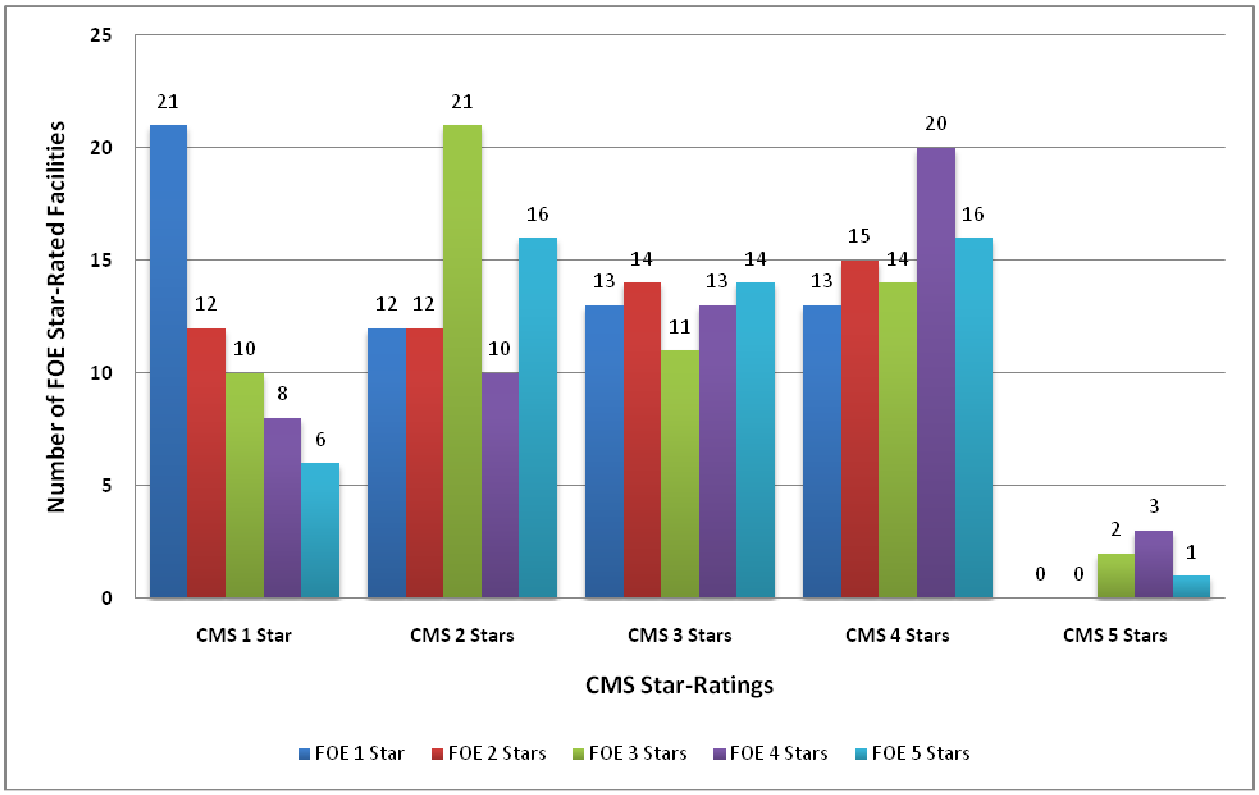
CMS Star-Ratings Source: *Medicare Nursing Home Compare* (information on website last updated on June 17, 2009).
FOE Data Source: *Oklahoma Nursing Home Ratings* (information on website last updated on April 2, 2009 with performance data from Q4-08).

Direct Care Hours

The Nursing Home Compare staffing measure is based on two equally weighted components: (1) registered nurse hours per resident day and (2) total staffing hours (registered nurse, licensed practical nurses and nurse aid hours) per resident day. Similarly, the Focus on Excellence program measures the ratio of direct care staffing hours to residents. The number of nurse and nursing assistant hours are combined to create a single score.

Exhibit 4-6 on the following page compares direct care ratings across the two programs for the 277 facilities appearing on both websites for this measure. While the average ratings are much closer than for state survey compliance – 2.96 for Focus on Excellence versus 2.66 for Nursing Home Compare – there are still many individual facilities whose scores differ by two or more stars between the two sites.

Exhibit 4 – 6 – Direct Care Hours Rating Comparison



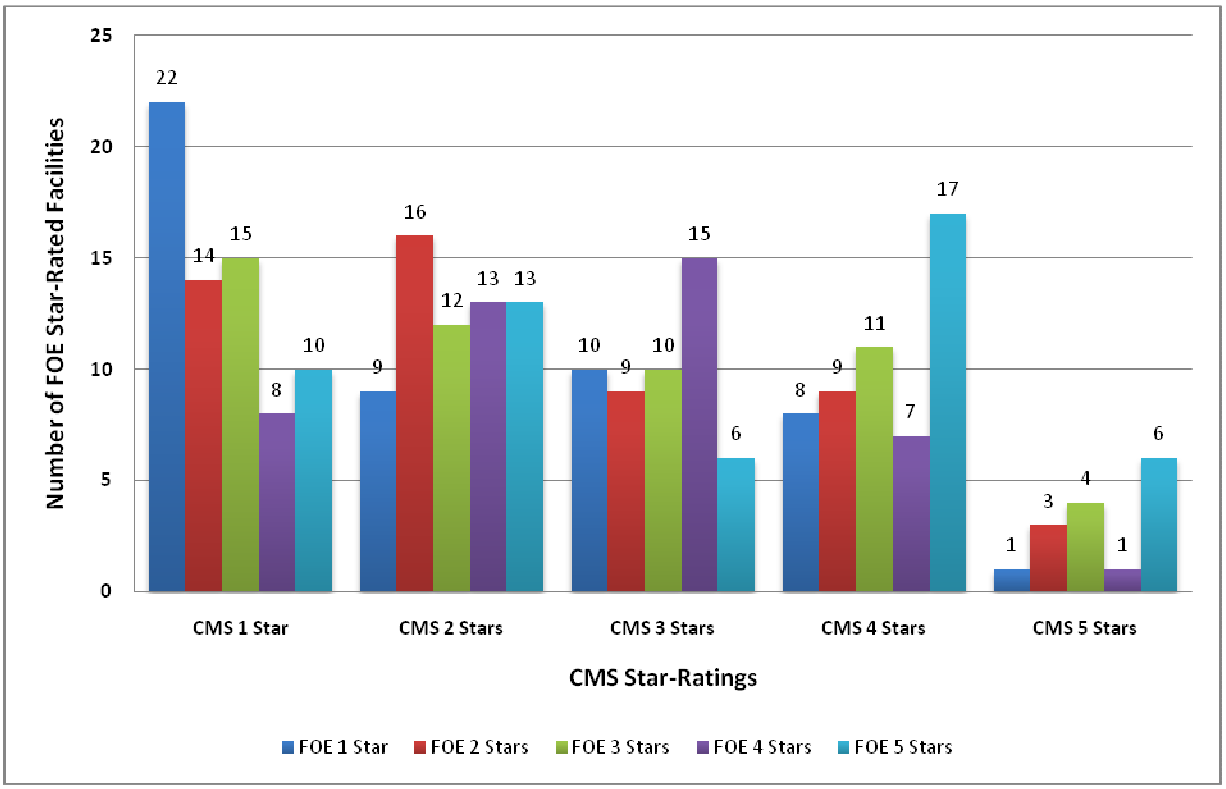
CMS Star-Ratings Source: *Medicare Nursing Home Compare* (information on website last updated on June 17, 2009).
FOE Data Source: *Oklahoma Nursing Home Ratings* (information on website last updated on April 2, 2009 with performance data from Q4-08).

Clinical Outcomes

Nursing Home Compare generates a star-rating for its quality measure domain based on a facility's performance on a subset of ten MDS-based indicators. (As with the health inspection measure, CMS awards five stars to the top ten percent of facilities.) Focus on Excellence measures similar clinical outcomes, including the prevention of unnecessary catheterizations; reduction of physical restraint use; and prevention of pressure sore development. Focus on Excellence also takes into account the number of falls and nutritional support provided to residents for a total of five measures.

Exhibit 4-7 on the following page compares clinical outcome ratings across the two programs for the 249 facilities appearing on both websites for this measure. The average ratings are fairly close – 2.95 for Focus on Excellence versus 2.52 for Nursing Home Compare – although Focus on Excellence has significantly more five star facilities than does Nursing Home Compare (52 versus 15). This reflects the use of the ten percent cutoff by CMS.

Exhibit 4 – 7 – Clinical Outcomes Comparison



CMS Star-Ratings Source: *Medicare Nursing Home Compare* (information on website last updated on June 17, 2009).
FOE Data Source: *Oklahoma Nursing Home Ratings* (information on website last updated on April 2, 2009 with performance data from Q4-08).

Overall Ratings

Nursing Home Compare applies an algorithm based on the three measures to calculate an overall star-rating, with the heaviest weight accorded to health inspection surveys. In contrast, the Focus on Excellence program weighs all ten measures equally to generate an overall star-rating.

Despite this difference, and the variation in results for the three measures found in both systems, the overall ratings in Focus on Excellence and Nursing Home Compare substantially overlap. As shown in Exhibit 4 – 8 below (table on following page and chart on second following page), over three-quarters of the 273 facilities with an overall rating on both sites either have the same number of stars (blue cells) or differ by only one star (yellow cells). The greater congruence on the overall rating is apparently due to the effect of Oklahoma's additional measures, which as a group are driving the ratings toward those awarded on Nursing Home Compare.

Exhibit – 4 – 8 – Overall Ratings Comparison

	FOE Star-Rating				
CMS Star-Rating	**1**	**2**	**3**	**4**	**5**
1	12.5%	6.2%	4.4%	2.2%	1.1%
2	4.8%	7.0%	5.9%	3.7%	0.0%
3	2.6%	5.5%	4.0%	4.8%	1.5%
4	1.1%	7.0%	5.9%	9.5%	4.0%
5	0.0%	0.7%	1.8%	2.2%	1.8%

CMS Star-Ratings Source: *Medicare Nursing Home Compare* (information on website last updated on June 17, 2009).
FOE Data Source: *Oklahoma Nursing Home Ratings* (information on website last updated on April 2, 2009 with performance data from Q4-08).

Only three facilities received five stars from Focus on Excellence and one star from Nursing Home Compare and none had the reverse circumstance. A detailed comparison of the three facilities is presented in Exhibit 4 – 9 on the second following page. As it shows, the main differential for two of the facilities was clinical outcomes, with Focus on Excellence awarding a high number of stars and Nursing Home Compare awarding the minimum of one star, due to incomplete data.

The third facility's greatest gap was on the state survey compliance/health inspection measure. The CMS survey for that facility was dated April 14, 2009 and cited 41 deficiencies, including in (but not limited to) the areas of mistreatment, quality of care, resident assessment, resident rights, nutrition and dietary. Since Focus on Excellence awards five stars to facilities with zero care-related deficiencies, the difference appears to be related to timing and use of two different surveys in the assignment of stars.

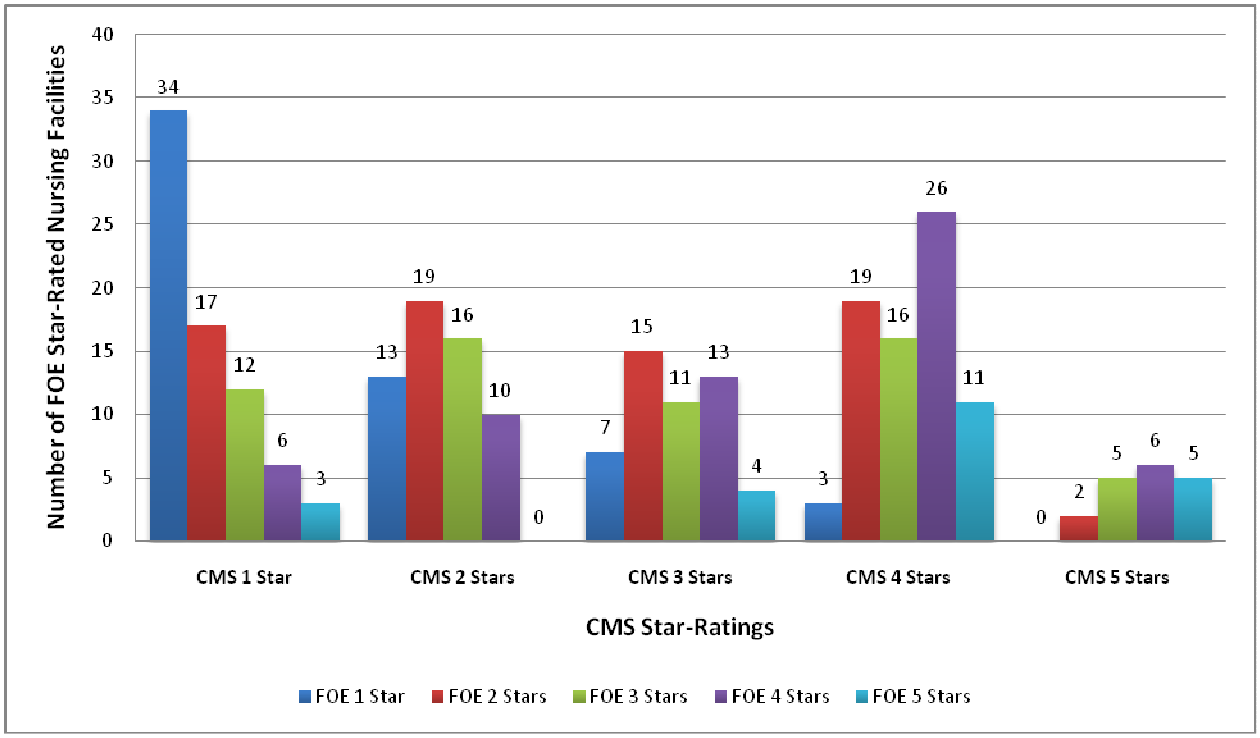
While any variation beyond one or two stars is unhelpful to consumers, the large overlap between the two sites is important, given their different methodologies and update intervals. Differences in timing will be difficult to reconcile, since Oklahoma generally updates more frequently. Most stakeholders interviewed by PHPG expressed a strong preference for the Focus on Excellence data due to its more frequent updating and larger number of measures.

However, there are steps that could be taken to narrow the gap on the state survey compliance and clinical outcome measures, which in turn would pull the overall ratings closer together. As discussed in greater detail in chapter four, many stakeholders favor suspending nursing facilities that fall below a pre-defined threshold on care-related deficiencies. A facility incurring the deficiencies noted in the April 2009 survey would immediately lose its five-star rating. This would not entirely eliminate timing-related discrepancies, but would bring the two sites into better alignment, assuming a suspension lasted for some minimum period of time.

The clinical outcomes measure is one in which CMS may have the superior methodology, as it evaluates more areas and imposes one star on facilities with incomplete data. Also, as noted earlier, CMS takes its data from MDS while My InnerView relies on separate nursing facility reports. Although Oklahoma's data can be more up-to-date, MDS is a recognized standard for clinical reporting.

The OHCA could consider adopting Nursing Home Compare MDS data for Focus on Excellence, so that the two sites match on this measure. Nursing facilities actually submit MDS data to the OHCA today, making it readily available. Assuming Oklahoma adopts the CMS methodology, this also would result in fewer five star facilities within Focus on Excellence.

Exhibit – 4 – 8 part 2 – Overall Ratings Comparison



CMS Star-Ratings Source: *Medicare Nursing Home Compare* (information on website last updated on June 17, 2009).
FOE Data Source: *Oklahoma Nursing Home Ratings* (information on website last updated on April 2, 2009 with performance data from Q4-08).

Exhibit – 4 – 9 – Overall Ratings Comparison for "1 Star/5 Star" Facilities

		Number of Stars			
		Overall	State Survey/Health Inspection	Direct Care Staffing	Clinical Outcomes
Facility "A"	CMS	1	2	1	1
	FOE	5	4	4	4
Facility "B"	CMS	1	2	3	1
	FOE	5	5	3	5
Facility "C"	CMS	1	1	3	2
	FOE	5	5	5	3

Website Features

Both Focus on Excellence and Nursing Home Compare enable consumers and providers to pull-up information on nursing facilities in their communities. The information supplied by both programs serves as a starting point for consumers when selecting a long-term care facility.

Consumers and providers using the Focus on Excellence website have access to a greater array of measures, including satisfaction ratings, than do visitors to the CMS site. As noted, the Focus on Excellence star-ratings also are updated more frequently and have a shorter look-back period than those posted on the CMS site.

However, the Nursing Home Compare website enables its users to view the number of survey inspection deficiencies for each facility, rather than simply seeing the number of stars awarded. Nursing Home Compare site-users also are able to see more detailed data on the number of direct care hours each facility provides and the quality measure percentages which take into account aspects of residents' health, physical functioning, mental status and overall well being. This website further enables individuals to view fire safety inspection results.

The additional functionality of the Nursing Home Compare website, and the potential for it to be replicated by Focus on Excellence is discussed further in chapter five.

CHAPTER 5 – STAKEHOLDER INTERVIEWS

The success of Focus on Excellence ultimately depends on the support of providers, consumers and other stakeholders. If providers lose confidence in the fairness or integrity of the system, participation will drop. If too many providers are absent from the site, consumers and their advocates will pay no regard to comparative rating data.

PHPG conducted interviews with stakeholders in Oklahoma to assess their satisfaction with the program, discuss concerns regarding its fairness and integrity and explore opportunities for improvement. Exhibit 5-1 identifies stakeholders interviewed, by type.

Exhibit 5 -1 – Stakeholder Interviews

Category	Stakeholders
Providers	• Nursing facility owners and administrators (multiple) • Executive directors of state associations
Consumers	• Office of Long Term Care Ombudsman • American Association of Retired Persons (AARP)
State Agencies	• Department of Health • Department of Human Services • Department of Mental Health and Substance Abuse Services • Oklahoma Health Care Authority

In the interviews, PHPG consultants addressed the following topics:

- Perceptions of the measures used in Focus on Excellence
  - Relationship to quality
  - Accuracy and integrity of data
- Recommendations for adding or removing measures
- Perceptions of star rating system and pay-for-performance methodology
  - Transparency
  - Reasonableness
- Perceptions of CMS Nursing Home Compare versus Focus on Excellence
- Awareness of, and attitudes toward, Focus on Excellence among providers and consumers (based on their experience)
- Recommendations for improving website awareness and use by consumers

PHPG also presented preliminary findings in two public meetings, one organized by the OHCA and another by state legislators. Comments from stakeholders at the two meetings were taken into consideration in preparing the final report.

Interview/public meeting findings and related recommendations are presented below, starting with general perceptions and moving on to individual system components.

General Perceptions of Focus on Excellence

Stakeholders in Oklahoma endorse the concept of providing financial incentives for quality improvement through a system like Focus on Excellence. The program generally is seen as working in conjunction with the new variable payment for direct care staff hours to encourage quality improvement throughout the industry.

Stakeholders also recognize the program is still in an early phase. Many providers spent the first year becoming familiar with reporting requirements and only now are taking steps to improve their ratings and increase their incentive payments.

At the same time, stakeholders did express concerns about three aspects of the program: the threshold for earning incentive payments; the transparency of the star rating system; and the integrity of some data collection and reporting processes. And while not a concern, several stakeholders endorsed adding another quality measure to the current list of eleven. Each of these items is addressed separately below[39].

At the legislative hearing held in mid-September, program critics also raised concerns with respect to the program's adherence to HB 2842 mandates; the awarding of stars to facilities with serious state survey deficiencies; and the frequency with which the Focus on Excellence and CMS Nursing Home Compare websites disagree. Each of these issues is addressed elsewhere in the report.

One speaker at the meeting also recommended that nursing facilities be required to spend incentive payment dollars in areas to be specified by the state, including: video monitoring systems; criminal background checks; employee evaluation testing; secure card monitoring systems; abuse response training; and liability insurance/risk management. Such an action would require a statutory change, as the OHCA does not have the legal authority to mandate where facilities spend their Medicaid dollars. Because many nursing facilities view the incentive payments as withholds from their base payment rates, they likely would strongly resist any such restriction on use of revenues.

[39] While there were stakeholders on both sides of nearly every issue, the concerns addressed in this chapter were raised by a significant majority of the persons interviewed.

Incentive Payment Thresholds

Overview of Issues

Focus on Excellence began with no Oklahoma-specific data available to establish performance benchmarks in most categories. For example, no previous data had been gathered on resident/family satisfaction rates using a uniform survey instrument and methodology.

The OHCA and My InnerView elected to begin with a relative ranking system, in effect grading on a curve. The OHCA also decided to distribute incentive payments broadly, using the 50th percentile (median) as the cutoff within every measure but the state survey.

One of the OHCA's goals in selecting this approach was to encourage participation by a majority of the nursing facilities in the state. The strategy worked, as the participation rate stands at 95 percent. Oklahoma has achieved, through a voluntary system, what others like Georgia and Iowa accomplished by mandating participation.

Looking forward, many stakeholders are now eager to see the program hew more closely to its name, by gradually raising the threshold for incentive payment eligibility. The expectation is that higher standards will contribute to continued quality improvement and will increase the reward for facilities that meet or exceed the standard by distributing the pool of dollars across a smaller number of providers. About one-half of the stakeholders also favor rewarding facilities that show substantial improvement over time, even if their absolute rating is low.

In addition, many stakeholders believe that one measure – state survey compliance – should serve as a threshold for participation in the incentive payment program and star-rating system. They believe facilities that fail to meet some defined letter grade threshold should be suspended from the program until their deficiencies are addressed.

Similarly, many stakeholders believe that the measures need not be weighted equally. Some, like occupancy, bear a less direct relationship to quality than others, such as quality of life, and should carry a lesser weight.

Recommendations

PHPG recommends the OHCA and My InnerView, in collaboration with providers and other stakeholders explore raising the standard for incentive payments in either of two ways: 1) increase the percentile threshold over time (e.g., 10 percent per year for two years) or 2) establish absolute thresholds for each measure, which again could be raised gradually over time. If an absolute threshold is used, it should be calibrated so that around 30 percent of facilities earn an incentive payment on each measure. This should be sufficient to encourage continued participation while truly rewarding "excellence".

The OHCA and My InnerView also should consider establishing a second incentive payment tied to improvement in performance. Facilities that fail to meet the new minimum standard, but that show substantial and sustained improvement could be awarded a smaller payment as recognition of their progress. However, the second track should also have a minimum acceptable level of performance, such as the 30th percentile, that excludes very low performing facilities, no matter how great their improvement. (This is the methodology employed in the Kansas and Utah programs.)

PHPG also recommends using the state survey compliance standard as a threshold for inclusion in the incentive payment pool and star system. Some providers expressed skepticism about the objectivity of the survey process, but it is a core quality assurance oversight mechanism at both the federal and state levels. The threshold can be set at a lesser standard than is used for state survey compliance incentive payments, to ensure that only serious violations result in a suspension. A reasonable cutoff could be a letter grade of "F" or "G". (See exhibit 2-2 for letter grade definitions.)

Finally, the OHCA and My InnerView should explore setting different weights for the individual quality measures. Any weighting scheme will be somewhat arbitrary (including equal weights, as used now) but there is general consensus in the stakeholder community that staffing and satisfaction data is among the most important and occupancy among the least.

One weighting guide available to the OHCA is the Focus on Excellence website, where consumers have the opportunity to rank what they consider the three most important measures when generating comparative reports. The most frequently selected items could be given a greater weight in any future scheme.

Transparency of the Star Rating System

Overview of Issues

The star rating system on the Focus on Excellence website presents summary results (the stars) and brief descriptions of what each measure represents. However, the actual data underlying the stars is not available to consumers or other stakeholders.

The star system is not intended to be the only or even primary method by which consumers select a nursing facility. It is meant to be an accessible source of comparative data, but not a substitute for actually visiting a facility and interviewing residents and staff. Some stakeholders, including consumer advocates, are therefore unconcerned about the lack of detail on the website. They believe visitors to the site are adequately served with a quick reference tool like the stars.

The majority of stakeholders, however, favor sharing additional information with website visitors regarding the underlying basis for the scores. The CMS Nursing Home Compare website shows the actual data driving a particular star-rating for a facility (e.g., actual health inspection data), while the Minnesota Report Card website offers very detailed information on the methodology (e.g., a full copy of the resident satisfaction survey instrument). Both sites allow users to explore the measures in as much or as little detail as desired.

Recommendations

While not every consumer will be interested in the detail of the star ratings, having it available adds credibility to the system. There also will be some consumers who seek out more detailed information in advance of visiting a nursing facility, even "arming" themselves with the data so they can review it with the administrator.

At a minimum, PHPG recommends making available the most recent state survey, either directly on the website or through a link to the Department of Health. The underlying data for other measures could be provided outright (e.g., occupancy rates) or in summary fashion, if the total amount of data would be overwhelming.

For example, global resident/family satisfaction results could be made available, even if all satisfaction survey data is not, while taking care to ensure the summary data aligns with the star rating so as not to create confusion. Data collection instruments, such as the satisfaction surveys and nursing facility reporting tools, also could be posted on the website for interested visitors.

As discussed in chapter four, PHPG also endorses My InnerView's recommendation that historical ratings for nursing facilities be available on the site. Visitors should have the option to pull-up star ratings for the previous two years (or a similar look-back period) to provide a greater context for judging the stability of a facility's ratings over time.

Quality Measure Data Integrity

Overview of Issues

My InnerView takes steps to protect the integrity of the data collection and submission process for each of the quality measures. Providers are trained on appropriate procedures and incoming data is examined for anomalous findings that might indicate errors or fraud.

Despite these steps, many stakeholders, including providers, expressed concern about the integrity of the process and the potential for results to be skewed by submission of inaccurate information. There is no evidence that more than a small number of providers have submitted

erroneous data. However, the concern among stakeholders is widespread and, if left unaddressed, could lead to a drop in confidence, and participation, in the program.

The specific issues vary by measure. However, PHPG recommends as a general step that the OHCA distribute a letter to participating providers reminding them of the importance of adhering strictly to data collection protocols when submitting information. Facility owners or administrators should be required to sign an attestation acknowledging that intentional misrepresentation of data could be construed as Medicaid fraud, given that the data is directly linked to payments. An updated letter should be sent, and a fresh attestation attained, at the start of each program year.

Resident/Family Satisfaction Survey

The resident satisfaction survey is a key data collection instrument, contributing to the generation of two quality measures. Nursing facilities are responsible for distributing and collecting surveys from residents; My InnerView also instructs them to provide assistance completing the survey to any resident who requests it.

No evidence was presented to PHPG that nursing facility staff have interfered with the survey process by influencing resident responses. In fact, a comparison of satisfaction ratings by residents assisted by staff members versus residents assisted by others found slightly lower satisfaction among the staff-assisted group[40]. However, there is a perception among stakeholders, including providers, that the process could be "gamed" by facilities that wished to do so.

PHPG recommends the OHCA and My InnerView consider a series of simple confidence building steps to ensure the integrity of the survey process. Specifically:

- Include a statement in the general letter from OHCA stressing that facilities should not interfere with the confidentiality of the survey process;
- Alter the survey design to indicate it is being issued by the state of Oklahoma (currently, the surveys are "branded" as being issued by the facility;
- Add a 1-800 number on surveys for respondents to call to report any facility interference (the number should be maintained by My InnerView)
- Include an attestation and signature line on the survey instrument, for any staff member assisting in its completion. With their signature, the employee will affirm that their role was limited to recording responses; and

[40] This comparison was performed by My InnerView at PHPG's request. Approximately 42 percent of the surveys were completed with the assistance of a staff member, 36 percent were completed with the assistance of someone other than a staff member, 18 percent were completed unassisted and four percent did not specify.

- Explore having an independent third party available onsite to serve as an additional resource for the survey process. Trained individuals, including local volunteer ombudsmen could be stationed in nursing facilities on survey days to distribute and collect instruments for return to My InnerView, as well as to provide assistance to any resident requesting help.

Employee Satisfaction Survey

The employee satisfaction survey is another key data collection instrument, with responses used to generate two quality measures. Nursing facilities are responsible for distributing and collecting surveys from employees at the facility. My InnerView believes onsite distribution is essential for ensuring an adequate response rate; in its experience, surveys mailed to the employees' homes are less likely to be completed and returned.

Stakeholders, including providers, are particularly concerned about the potential for undue influence of employees by nursing facility managers. There is anecdotal evidence that a small number of facilities have sought to encourage favorable responses, although there is no proof that their employees complied.

PHPG recommends the same confidence building steps be taken for the employee survey as for the resident survey. This includes using an independent party to serve as an onsite survey "proctor" with responsibility for distributing and collecting surveys, as well as monitoring their completion.

Staff Retention/Turnover and Nursing Staffing

My InnerView provides instructions to nursing facilities on how to compile and report data for staff retention/turnover and nursing staffing items, which together account for three of the quality measures. The main concern raised by stakeholders was that some providers are reporting their information improperly, and in a way that favors their facilities. Stakeholders pointed to specific examples, such as a provider that excluded very short term staff (e.g., less than one week of employment) from the turnover statistics on the grounds that they "never really worked here" and another provider that included administrative personnel in its direct care staffing data.

These types of errors may be unintentional, but they have a corrosive effect on the system if left unaddressed. PHPG recommends that My InnerView undertake regular refresher training with providers on submission procedures for these items. The OHCA's letter also should include a list of do's and don'ts (as an attachment), for review and sign-off by the facility owner or administrator. PHPG further recommends that My InnerView institute a formal outlier analysis to identify nursing facilities whose data lies outside a pre-established threshold (e.g., more than one standard deviation from the mean) for secondary review and follow-up as necessary.

Clinical Measures

The major concern expressed about the clinical measures is the frequency with which they fail to match the corresponding data on the CMS website (see chapter four). As discussed earlier, this is partly a timing issue and partly due to differences in methodologies between the two programs. For example, CMS includes ten measures while Oklahoma includes only five.

PHPG recommends the OHCA and My InnerView consider using MDS data, like Nursing Home Compare, so that the two websites are closer in alignment. The OHCA and My InnerView may also wish to adopt the star rating methodology used by CMS for this particular measure, again to bring the two sites into better agreement.

State Survey

Some providers criticized the state survey as being subjective, but it is a core measure that should be part of any pay-for-performance system. Even its critics generally acknowledged that the process captures serious deficiencies and most agreed surveyor consistency and objectivity has improved in recent years.

As discussed earlier, PHPG recommends that the most recent survey be made available to website visitors, either directly or through a link to the state Department of Health. (OSDH does not currently post the surveys online but has indicated a willingness to work with the OHCA on this matter.) This will allow interested consumers to judge for themselves the importance of deficiencies that nursing facilities may consider relatively minor.

Occupancy

Providers are critical of the occupancy measure, believing it discriminates against rural facilities located in areas with declining populations. PHPG recommends the OHCA and My InnerView consider establishing urban and rural “peer groups” so that facilities are compared to their geographic counterparts. Separate incentive payment thresholds could be established based on the relative difference in occupancy between the two portions of the state.

Additional Quality Measure

Stakeholders consider Focus on Excellence to be comprehensive in scope. They recognize that it contains more quality measures than CMS Nursing Home Compare or most other state systems. However, several stakeholders suggested recreational, or social activities be considered as a new, standalone measure, given their importance to the quality of life of many residents.

Support for this measure goes back to the Interagency Task Force, which included it in its recommendations. The Task Force went so far as to create a prototype data collection tool to query facilities about the number of activities offered each month and the level of participation.

Recreational and social activities are addressed today on the resident/family survey, which asks about the availability of "meaningful activities". However, this item is part of a much larger instrument and does not capture information about activities in the manner envisioned by the Task Force then or stakeholders today.

No other state includes recreational activities as a quality measure. (Iowa considers the effectiveness of the resident council.) However, the OHCA and My InnerView may wish to consider the desirability of adding the recreational activity measure in light of its importance to stakeholders.

If a decision is made to further explore its efficacy, the next step should be to confer with providers on how the data could be reliably collected and reported without creating a significant new burden. The OHCA could enlist a small number of providers in a pilot test of the variable and reimburse them for their efforts through a temporary upward adjustment in their incentive payment.

PHPG does not recommend that an additional measure be added statewide unless another measure, such as occupancy, is removed. This would be to prevent dilution of the remaining measures, which already only account for ten percent of the total score apiece.

Advisory Group

During interviews for this evaluation, stakeholders proved to be knowledgeable about Focus on Excellence and in most cases invested in its success. Many of PHPG's recommendations originated with consumer and provider stakeholders, based on their first-hand knowledge of the program.

It would be to the program's benefit to provide a regular forum for stakeholders to consult with the OHCA and My InnerView and offer feedback on potential refinements on quality measures, data collection and other system components. The OHCA should consider establishing a standing advisory group consisting of consumers/consumer representatives, providers and agency stakeholders (e.g., OSDH survey unit director) to meet quarterly, or as needed. One of the first assignments to the group could be to explore ways to increase awareness and use of the Focus on Excellence website.

CHAPTER 6 – CONCLUSIONS

Pay-for-performance systems such as Focus on Excellence represent the future for Medicare and Medicaid. Oklahoma is one of a small group of states to create a long term care pay-for-performance model, but with CMS undertaking its own pilot program their growth at the state level is likely to accelerate.

Oklahoma's system stands-out among its state counterparts as being among the most comprehensive in scope. Focus on Excellence also compares favorably to CMS Nursing Home Compare in terms of its comprehensiveness and freshness of data.

Oklahoma is also a leader in seeking to make comparative data available to consumers in a user-friendly format. Only CMS and one other state have attempted anything similar. The Focus on Excellence website does not appear to be heavily trafficked today (based on anecdotal information) but has the potential to be an important resource for consumers preparing to make an onsite visit to a nursing facility under consideration for themselves or a family member.

The first year of Focus on Excellence was a learning period, as the OHCA used a low threshold in the incentive payment methodology to encourage participation and nursing facilities became accustomed to the data reporting requirements. The program has achieved its first objective by drawing-in nearly every Medicaid provider in the state.

The coming year will be critical for moving the program forward. The high level of provider participation gives the state the necessary leverage to begin raising the threshold for incentive payments. The OHCA can move over time to define "excellence" in a manner that targets payments to high performing facilities while encouraging lower performing facilities to improve.

Concurrent with these refinements, the OHCA and My InnerView should move quickly to ensure the transparency and integrity of the Focus on Excellence data reporting process. A series of simple-to-implement confidence building measures will bolster support for the program and ensure payments are directed to deserving providers.