



*Washington State*  
Department of Social  
& Health Services

**Report to the Legislature**

**Report on Designing a Quality  
Incentive Payment Program for  
Skilled Nursing Facilities**

RCW 74.48.090

January 1, 2013

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## EXECUTIVE SUMMARY

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RCW 74.48.090 required the Department of Social and Health Services (“the Department”) and the Department of Health to consult with the Washington State Health Care Association and Aging Services of Washington (now renamed LeadingAge Washington) to design a quality incentive payment program for skilled nursing facilities and submit the design of the system to the relevant policy and fiscal committees of the legislature by January 1, 2013. The program should use benchmarks for quality that represent a real improvement for the majority of facilities yet are feasibly attainable. The goal of the quality incentive program is to establish a framework that encourages improvements in quality in Washington skilled nursing facilities, while being responsive to the changing needs of nursing facility residents.

The recommendation closely follows the quality incentive program developed for hospitals in Washington. The proposal enclosed establishes a set of five performance metrics on which each facility will be scored. If the average of the scores from the five metrics is five or greater, the facility will receive an add-on to their rate. The program will start July 1, 2014. The Department would use data from performance in 2013, which would be collected in early 2014. Pursuant to an appropriation for state fiscal year 2014 and each fiscal year thereafter, assessments may be increased to support an additional one percent increase in skilled nursing facility reimbursement rates for facilities that meet the established quality incentive benchmarks.

Seven stakeholder workgroup meetings were held to gather the information used in this report.

## AUTHORITY

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In RCW 74.48.090, the Legislature specifically designated five principles to form the basis of a quality incentive program:

- (a) Evidence-based treatment and processes shall be used to improve health care outcomes for skilled nursing facility residents;
- (b) Effective purchasing strategies to improve the quality of health care services should involve the use of common quality

- improvement measures, while recognizing that some measures may not be appropriate for application to facilities with high bariatric, behaviorally challenged, or rehabilitation populations;
- (c) Quality measures chosen for the system should be consistent with the standards that have been developed by national quality improvement organizations, such as the national quality forum, the federal centers for Medicare and Medicaid services, or the federal agency for healthcare research and quality. New reporting burdens to skilled nursing facilities should be minimized by giving priority to measures skilled nursing facilities that are currently required to report to governmental agencies, such as the nursing home compare measures collected by the federal centers for Medicare and Medicaid services;
  - (d) Benchmarks for each quality improvement measure should be set at levels that are feasible for skilled nursing facilities to achieve yet represent real improvements in quality and performance for a majority of skilled nursing facilities in Washington state; and
  - (e) Skilled nursing facilities performance and incentive payments should be designed in a manner such that all facilities in Washington are able to receive the incentive payments if performance is at or above the benchmark score set in the system established under this section.

The Legislature also provided a source of potential funding for the quality incentive program. In reference to the nursing facility safety net assessment created elsewhere, the Legislature provided:

- (2) Pursuant to an appropriation by the legislature, for state fiscal year 2014 and each fiscal year thereafter, assessments may be increased to support an additional one percent increase in skilled nursing facility reimbursement rates for facilities that meet the quality incentive benchmarks established under this section.

## DEVELOPMENT OF PERFORMANCE MEASURES

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Before conducting any meetings, the Department researched nursing facility quality incentive measures used in other states. While the form and

function of the quality incentive measures varied greatly from state to state, none were operating in a way that fit the Legislature's directive for meeting the needs of Washington. However there were lessons to be learned from other states' trials and errors, for example not incorporating the add-on into the base rate, leaving flexibility to refine the measures as the program progresses, and finding the right number of measures without having too many or too few. The Centers for Medicare and Medicaid Services is also currently running a pilot quality incentive program in New York, Wisconsin, and Arizona that the Department examined. Additionally, the Department looked to the quality incentive program developed for hospitals in Washington. Many Medicaid clients move from hospitals to a skilled nursing facility setting and vice versa, so there is a benefit to ensuring the two programs complement one another.

As instructed by the Legislature, the Department met with representatives from the Washington Health Care Association and LeadingAge Washington in addition to other stakeholders. Meetings were held on May 17; June 26; July 26; August 14; August 22; September 7; and September 12, 2012.

In addition to consulting with external stakeholders, the Office of Rates Management met with representatives from Residential Care Services, another division within Aging and Disability Services Administration, to discuss clinical measures. One of Residential Care Services' responsibilities is the licensing and oversight of nursing facilities. These discussions included identifying which clinical measures need improvement within Washington, how information regarding those clinical measures is gathered and processed, and determining what a realistic goal regarding those measures would look like.

One concern of everyone involved was minimizing the cost of collecting new data. Thus, the focus turned to developing measures that the industry was comfortable with that used information skilled nursing facilities are already required to report and information that could be easily obtained.

Multiple types of measures were considered including clinical, staffing, reducing infections, cultural change, re-hospitalizations and Medicaid population. After consulting with the workgroup, the Office of Rates Management developed a proposed program. The five measures are:

- Development and treatment of pressure ulcers formed at the facility. Pressure ulcers dramatically lower the quality of life of a

resident and are preventable. Short stay pressure ulcers are used in the measure and are risk adjusted.

- Direct care staff retention/turnover. Consistency in staffing reduces medical errors as well as provides residents with familiar faces.
- Resident driven quality improvements in the facility. Resident driven quality improvements in a facility focus on making the daily life of the residents more comfortable and feel less institutional in addition to giving them some control over their day to day activities. This type of program can greatly improve the quality of life of the residents.
- Staff flu immunization rates. Nursing facility residents tend to be a vulnerable population and immunization of the staff helps reduce infections of the residents.
- Plan for addressing inappropriate re-hospitalizations. This measure requires facilities to develop a plan to reduce inappropriate re-hospitalizations. The necessary pieces of the plan are: inappropriate hospitalizations; discharge planning; use of SBAR (situation, background, assessment, recommendation) or a similar program; patient follow-up; utilization of teach-back; and having an RN or physician on staff 24 hours a day.

In addition there is an entrance condition that must be met to participate in the program. Any facilities found to have provided substandard quality of care<sup>1</sup> in the measured year will not receive the add-on regardless of their performance on the five measures. If a finding of substandard quality care is later overturned, a facility may notify the Office of Rates Management and the denial of the quality incentive add-on will be reversed and the facility will retroactively receive any payments missed due to a cleared finding of substandard quality of care.

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<sup>1</sup> Substandard quality of care is defined in 42 CFR §488.301: *Substandard quality of care* means one or more deficiencies related to participation requirements under § 483.13, Resident behavior and facility practices, § 483.15, Quality of life, or § 483.25, Quality of care of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm. Definitions, 42 C.F.R. § 488.301 (2003).

## METHODOLOGY

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The Department's methodology recommendation closely follows the quality incentive program developed for hospitals in Washington. There are many benefits to running the two programs in the same manner including making it easier to align the efforts of the two institutions to work towards common healthcare goals and allowing both programs to share successes and failures with one another to improve both programs.

Each facility will be assessed using all five measures. The data for some measures is already being collected from facilities and will be used for this program. For measures where data is not currently being collected, the Washington Health Care Association and LeadingAge Washington will collect the data from the facilities and turn it over to the Office of Rates Management. Facilities that are not members of an association may still submit quality incentive data to either professional association mentioned above.

The Office of Rates Management will process the data to determine the scores for each facility on the measures. Each facility will be given a score between zero and ten for each measure. The points will be added together and divided by the number of measures. If the average score is five or greater, the facility will qualify for a one percent add-on to their Medicaid rate. The rate may or may not be subject to settlement, depending on direction from the Legislature.

The benchmarks must be feasible for all facilities but represent real improvements in quality. This means benchmarks should be set to incentivize the improvement of quality care to qualify, but the cost and effort of improvement is not insurmountable. The Department listened to concerns and worked with industry representatives to compromise in the formation of the benchmarks to create a program both sides agreed on. The benchmarks are set so that they are fair but encourage genuine improvement. For measures where data is already collected, genuine improvement can be measured compared to benchmarks established using historical numbers. For measures where data is not already collected, the early stages of the program will be used to establish benchmarks for improvement in the future. While neither the Department nor the associations had full control over choosing the benchmarks, both had input at every step and the resulting benchmarks are a reflection of that. As this program moves forward, discussions will continue to be

involved in determining the benchmarks as well as evaluating the facilities for scoring.

Participation in this program is open to all skilled nursing facilities that receive Medicaid payments. A facility may choose to not submit data for the measures that require reporting, in which case those measures will be assigned scores of zero. Measures determined using information collected by the Department will be calculated for every facility receiving Medicaid payments.

### **Pressure Ulcers – Short Stay**

Threshold	Worse	Same	Improved	None Created
Point Award	0	3	5	10

Short stay pressure ulcers will be measured using the Quality Measures from the Centers for Medicare and Medicaid Studies, which are risk adjusted. The measure looks at the entire resident population. Information on pressure ulcers will be collected by the Department.

### **Direct Care Staff Turnover**

Threshold	60% or more	50%-59%	40%-49%	39% or less
Point Award	0	3	5	10

Information regarding turnover is currently collected by the Department on the nursing facility cost reports.

### **Staff Immunizations**

Threshold	60% or less	61%-69%	70%-79%	80% or more
Point Award	0	3	5	10

Staff immunization data will be collected by the associations and turned over to the Department.

### **Plan for re-hospitalizations**

Threshold	3 or fewer sections approved	4 sections approved	5 sections approved	6 sections approved
Point Award	0	3	5	10

The plan will be reviewed and approved by the Department. In the second year of the program this metric will be readdressed to become a measure of actual re-hospitalizations. The plan required in the first year needs to address:

- Community Partnerships – Documentation that infrastructure is in

place that includes relevant community partners

- Data Reporting – Evidence of collection and analysis of data upon which to create an informed plan
- Strategic Plan for Prevention of Unnecessary Re-hospitalizations – Creation of strategies to prevent patients from needless visits to the hospital
- Follow-Up – Create strategies addressing patients who are readmitted to the hospital
- Staff Participation in Continuing Education
- Meet Medical Needs – Create a plan to have a physician, physician assistant, or advanced registered nurse practitioner on site or available to meet the medical needs of residents 24 hours a day

The associations will collect the plans from the facilities and turn the information over to the Department.

### Resident Centered Quality Improvement

Threshold	No sections approved	One section approved	Two sections approved	Three sections approved
Point Award	0	3	5	10

Facilities will choose, develop, and execute improvement in three of the four resident centered quality improvement categories below. The improvements will be enhancements beyond current minimum regulatory requirements. The categories are:

- Dining;
- Facility practices such as bathing time or waking time;
- Other resident centered improvements as proposed by the facility; and
- Usage of the Pioneer Network Artifacts of Culture Change Assessment<sup>2</sup> to monitor cultural change implementation and maintenance and to establish a baseline for future resident driven quality improvement measures.

Information regarding the categories chosen by the facilities, their plans for improvement, and data on their improvement will be collected by the associations and turned over to the Department.

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<sup>2</sup> The Pioneer Network Artifacts of Cultural Change Assessment is used to “assess readiness, implementation and sustainability of person-directed care...[and] fills the purpose of collecting the major concrete changes homes have made to care and workplace practices, policies and schedules, increased resident autonomy, and improved environment.” Artifacts of Culture Change, <http://www.pioneernetwork.net/providers/artifi> Acts (last visited October 16, 2012).

The developed quality incentive program rewards facilities that provide high quality care while encouraging improvement in lower performing facilities by setting benchmarks that are realistically attainable. The benchmarks for each quality improvement measure are to be set at levels that are feasibly attainable for all participating skilled nursing facilities. Any facility that meets the necessary average and has not provided substandard quality of care will receive the add-on. There is no competition for the funds between facilities and it is possible for every facility to qualify for and receive the add-on in any given measured period.

## TIMELINE FOR QUALITY INCENTIVE PROGRAM

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For implementation on July 1, 2014, the Office of Rates Management would raise the safety net assessment July 1, 2013, per an appropriation, to collect the money for the quality incentive payments. Data for the measures would be collected in calendar year 2013, giving the skilled nursing facilities time to examine the measures and adjust their behavior accordingly. Payments would then start at the beginning of fiscal year 2015 on July 1, 2014. If payments started July 1, 2014, the timeline would be as follows:

January 2013	The Department will notify the facilities of the proposed measures and timeline.
July 1, 2013	Facilities will start collecting data they are responsible for providing.
December 31, 2013	The first measurement period ends.
January 20, 2014	Plans to be developed and data that are collected by the facilities are due to the Department.
July 1, 2014	The add-on goes into effect.

## INDUSTRY CONCERNS

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The industry voiced concerns about the funding source for the QA program, but DSHS does not have the authority to specify what type of funding is used.

Other concerns were voiced regarding the benchmarks chosen and how they would be measured. The Department, listening to those concerns, worked with the industry representatives to compromise in the formation of the benchmarks to create a program both sides agreed on. While neither the Department nor the associations had full control over choosing the benchmarks, both had input at every step and the resulting benchmarks are a reflection of that.

## FUTURE WORK

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The Department will need to create and update rules in the Washington Administrative Code as required to administer this program. Rules regarding the structure of the program as well as rules regarding the funding will need to be reviewed on a yearly basis to assure that the program continues as intended.

After the first year of the program, the Office of Rates Management will reevaluate the program looking at the number of facilities that qualified and if the program is encouraging improvement. Additionally, the Office of Rates Management will continue to seek input from the associations as well as other government departments regarding whether the measures are still appropriate or if there are other areas that could be incorporated into the program.