



# **A Review of Nursing Home Medicaid Value-Based Payment Programs**

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## Executive Summary

State Medicaid programs have historically used a fee-for-service (FFS) reimbursement model for nursing homes, in which a flat all-inclusive fee, which is often acuity adjusted is paid for every day of services<sup>1</sup>. These per diem payments are intended to cover the costs-associated services rendered by the nursing home but typically exclude costs of medications, tests, procedures, clinician services, and hospitalizations. The per diem payments are made unrelated to the quality of care provided. Value-based payment (VBP) models, which adjust a provider's payment based on the quality of care provided to their patients, are often added to the FFS model. A well-designed VBP model has the potential to promote quality and efficiency but a poorly designed one may have little effect. In September 2020, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Directors (SMD) letter encouraging all states to adopt VBP programs as part of their Medicaid program<sup>2</sup>.

We identified 30 unique nursing home Medicaid VBP programs across 24 states. Two-thirds of the programs were established through statute. The funding for most programs was complex with poor transparency. Approximately two-thirds were funded by state and federal funds. The remaining programs were funded by state and federal funds supplemented with a provider tax. Some identified additional funds for the incentive payments while others carved out the incentive from existing funds. An average of 8 measures were used, with a range of 1 to 37 measures. When assessing performance on each measure, most states assigned points to each measure and then used an ordinal ranking system, often aggregating points and assigning facilities into different tiers. Some states used benchmarks set by CMS Five-Star rating system to judge performance, while others compared the facility to the state average or divided facilities into statistical groups. Most programs linked payment to the aggregate performance on all measures but some linked payment to individual measures. Payment was commonly an adjustment to the underlying Medicaid rate, but some paid a separate amount based on performance and the number of Medicaid days of service.

The Medicaid value-based payment programs reviewed in this study demonstrate the breadth of options that are available. Although some of this variation can allow for an effective program, not all program designs align with the best practices reported in the literature, or incorporated features that would incentivize better quality or better value for nursing home residents' care.

As a result of CMS' SMD, value-based payment programs may become more widely implemented in long-term care. States should retain the freedom to design a program that will best serve their unique populations, but they also have the burden to design effective programs. State Medicaid officials designing new VBP programs should align program features with best practices to obtain better value for their state funds. In addition, state program documents should describe all features of the program thoroughly and in plain language and made easily available to providers and the public. States should also include a plan to evaluate the effectiveness of their program and how to adjust it over time.

### Key Takeaways

- Programs should strive to align with expert recommendations and
  - be predictable, transparent, and consistent,
  - use stable performance benchmarks,
  - use tiered payment structure,
  - maintain a simple incentive structure.
- There is a lot of variation in reviewed nursing home Medicaid VBP program design features, and not all align with best practices.

## Introduction

Historically, state Medicaid programs have paid a single all-inclusive per diem amount for every Medicaid beneficiary<sup>1</sup>. Several services and treatments (i.e., medications, tests, procedures, treatments, and clinician fees) are excluded from this amount and are covered either by Medicare or Medicaid under varying arrangements, but most often in a fee-for-service arrangement. Because these per diem payments are distributed unrelated to the quality of care provided, they have been criticized for not incentivizing better quality<sup>3</sup>. Value-based payments (VBP) have been used as an alternative payment model to incorporate quality to the payment to nursing facilities<sup>4</sup>. Also known as pay for performance, these VBP programs link payments with the quality of care received by residents through varying arrangements thus promoting and incentivizing providers to focus on quality instead of volume of care.

Although the value-based payment model was widely celebrated at its inception, it has proven to be an imperfect solution with unintended consequences<sup>5</sup>. While value-based payment programs have the potential to incentivize quality, improve clinical outcomes, target health disparities, and lead to a more effective and efficient use of Medicaid funds, a poorly designed program can be ineffective or worse, have unintended harmful effects.<sup>6</sup>

Past evaluations of VBP programs in long-term care, other settings, or different insurance programs, such as Medicare or commercial insurance, have identified best practices for program design to achieve better quality<sup>7-14</sup>. These best practices fall into four broad categories: **establishment and funding or creating an incentive pool, performance measures, performance assessment, and link to payment** (Table 1).

Because state and federal Medicaid funding is limited, it can be challenging to identify additional funds to create and sustain the **incentive pool** used in VBP programs<sup>15</sup>. As such, states typically design the Medicaid VBP programs to be at minimum budget neutral for the state, though at the provider level this may result in redistribution of funds between providers or services such that some providers may experience cuts in payments while others may experience increases in payments<sup>9</sup>. Some states use a bed tax to help generate state revenue to support an incentive pool<sup>16,17</sup>, while others use a withhold or carve out of existing funds to create an incentive pool. Some states also use the VBP program as a cost cutting approach rather than as a program to recognize or incentivize better quality, which can lead to skepticism among providers<sup>18</sup>. VBP programs should not be used as a cost cutting tool but rather should be designed to achieve better value for the services provided. Programs should also strive for predictability and consistency and clearly define the targets related to the expected payment amounts under the VBP program.<sup>19,20</sup> In this way providers can appropriately plan and invest in

Category	Recommendation
Establishment and Funding	Be budget neutral
	Be predictable and consistent
Performance Measures	Address clinically relevant aspects of nursing facility care
	Be predictable and consistent
Performance Assessment	Address clinically relevant aspects of nursing facility care
	Compare performance to a stable benchmark
	Be predictable and consistent
Link to Payment	Offer an incentive large enough to enable facilities to invest in redesigning care and improving quality
	Create a simple incentive structure
	Create a tiered payment structure
	Be predictable and consistent

systems to achieve these quality targets, particularly when the changes or investments needed will span multiple years. Therefore, without program predictability and consistency it is hard for providers to plan and stay within their budget limits. To this end, programs should avoid drastic annual changes to either the measures, performance assessment targets, or incentive structure.

**Performance measures**, particularly quality measure selection, also has an impact on the success of the program. Quality measures and performance targets must address meaningful aspects of Medicaid beneficiaries' care in nursing facilities<sup>7,12</sup>. Otherwise, if the measures and benchmarks are not in alignment with the needs of the residents, facilities may instead focus on metrics more pertinent to the care and needs of their residents<sup>11</sup>. Additionally, parsimony in the total number of measures selected for the program is essential as too many measures dilute the impact of the program on providers' performance.<sup>21</sup>

The method of **performance assessment** can be consequential. The most effective way to engage facilities and promote improvement is to set a benchmark and create a tiered payment system that rewards facilities based on how close they come to meeting the benchmark.<sup>7,10,20</sup> If target thresholds are not set in a manner that allows some predictability, or that allows all providers the ability to reach the target despite their best efforts, they may give up trying altogether. A predetermined set benchmark that has tiers allows all providers, especially lower performing facilities, a chance to improve quality and receive the incentive. Overall, the methodology for assessing performance should be relatively simple and transparent, otherwise providers will not understand what they need to do to achieve the performance targets associated with a payment.

The size of the **payment** must also strike the right balance<sup>11</sup>. A payment that is too small will have no impact, while a payment that is too large may disadvantage poorly performing facilities especially if the payment structure is such that the incentive comes from withheld funds from the per diem rate. An effective incentive must also be large enough to enable facilities to invest in redesigning care and improving quality<sup>7</sup>. For example, if the cost to achieve the target (e.g., increase staffing level, hiring a nurse practitioner) is greater than the incentive payment received, then there is a disincentive to participate in the VBP program or pursue improvement on the measures. The incentive structure must also be simple and transparent, as overly complex incentive structures can lead to attenuated effects<sup>7</sup>.

On September 15, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director Letter encouraging all states to develop a Medicaid value-based payment program, unless they already had one in place<sup>2</sup>. The rule provided some guidance and lessons learned from states that already adopted a VBP program but was not prescriptive in any program features. Regarding the timing of this new rule, then CMS Administrator stated that "...by accepting value-based or capitated payments, providers are better able to weather fluctuations in utilization, and they can focus on keeping patients healthy rather than trying to increase the volume of services to ensure reimbursement. Value-based payments also provide stable, predictable revenue—protecting providers from the financial impact of a pandemic"<sup>2</sup>.

Value-based payment programs have the potential to change the provider reimbursement system, but they are an imperfect solution; without careful planning, they can be ineffective and even harmful. Given the wide variety of options for designing a value-based payment program, it is important to carefully think through the consequences of each component. CMS' State Medicaid Director Letter signified a shift in the payment policy priorities for all states, however, without clear recommendations, many states are left without much guidance as they develop a

new VBP program.

The last national survey of state Medicaid VBP programs for nursing homes in 2008 found nine states with such programs in effect and another five considering adopting such programs.<sup>22</sup> While the Medicaid and CHIP Payment and Access Commission (MACPAC) tracks Medicaid payment methodologies and whether states have an incentive program, the details of the program features have not been characterized nor compared to best practices.<sup>23</sup>

Therefore, in this study we sought to describe the features of existing nursing home Medicaid VBP programs in use across the nation and compare those features to VBP best practices specified in the literature. We hope that these findings can help states as they pursue Medicaid value-based payment programs for nursing facilities.

## Methods

### ***Identification of VBP Programs and Supporting Documents***

We surveyed all American Health Care Association (AHCA) state associations to identify which states had at least one Medicaid VBP program and collected program documents, if applicable (see Appendix 3 for survey). For all non-responders, we successfully reached out to them by either direct email or phone calls to verify the existence of a nursing home VBP program. For state documents that appeared incomplete or had missing data, we followed up with state trade association representative to track down any additional documents, ultimately achieving a 100% response rate by end of July 2021. In addition to reviewing the documents that were available to us, we also reviewed the states' Medicaid webpages including information about the VBP program.

### ***Data Abstraction and Descriptive Analyses***

We included a VBP program in our study when Medicaid payment was linked to quality of care in a nursing home. Prior to reviewing each program, we determined the specific program features of interest based on literature about VBP programs. The program features were grouped into four thematic areas: establishment and funding or creating an incentive pool, performance measures, performance assessment, and link to payment. All variables are described in Appendix 1.

We reviewed all the documents and coded each program as having or not having each feature and collected specific description or details for each feature (Appendix 1). When it was unclear how to classify a particular aspect of the program, we collectively reviewed the program and decided on its classification. In instances of incomplete documents or when submitted documents were not clear, we requested additional information and supporting documents from the state trade associations or state contacts. We used Microsoft Excel to document program details and generate descriptive statistics.

### ***Performance Measure Classification***

We classified each measure used in each VBP program based on the Donabedian and Agency for Healthcare Research and Quality paradigm for quality measures: structural, process and outcome measures, as well as cost and resource measures.<sup>24</sup> Structural measures relate to a facility's capacity and systems that enable the provision of high-quality care, such as employee retention rates, provision of continuing education to staff, and consistent assignment of staff to

residents. Process measures quantify efforts to maintain or improve the health of residents, including influenza vaccination, diabetes care, and cancer screening. Outcome measures assess how the care provided affected the health status of the residents. Examples of outcome measures include resident falls, hospitalization rates, and pressure ulcers. Cost and resource measures are essential to identify and provide incentives for providers to deliver higher-quality, lower-cost care.<sup>25</sup> A facility's operating expenses is one example of a cost and resource measure.

## ***Comparison to Recommend Best Practices***

We determined to what extent selected program components aligned with best practices from the literature (Table 1). We rated each program on predictability and consistency, use of a stable performance benchmark, type of payment structure, simplicity of incentive structure, and based on these assigned each program an overall score. For each VBP component feature, the features were given a score of 0 if it was not aligned with the best practices from the literature, a score of 1 if it was partially aligned, and a score of 2 if it was completely aligned. Components designated "M" were not mentioned in any documents we reviewed and thus were designated as missing. We were unable to assess states' budget neutrality for each program because this information could not be gleaned from the information that was publicly available or provided. Additionally, we did not assess whether the measures were clinically relevant and appropriate for the beneficiary population or if the incentives were large enough because it was outside the scope of this study. Delaware and New York were excluded from this portion of the analysis because the Medicaid Managed Care Organizations (MCOs) in those states are largely responsible for determining the details of their own VBP programs rather than the state Medicaid agencies.

For **predictability and consistency**, we scored a VBP program as "0," or not in alignment with the best practice, when the program allowed annual adjustments to components such as measures, performance thresholds, or incentives. Generally, one year is not enough time for facilities to make meaningful progress or for programs to determine the impact and effectiveness of the program component. Programs scored as "1," or partially in alignment with the recommendation, allowed occasional adjustments less frequently than annual adjustments. Programs scored as "2," or fully in alignment with the recommendation, only allowed changes to be made on pre-defined "rebasings" years, usually occurring every 3 or 5 years.

For use of **stable benchmark as a performance threshold** we rated a VBP program as "0," or not in alignment with the recommendation when the program compared a facility's performance to the state average or used a statistical distribution. Programs scored as "2," or fully in alignment with the recommendation, did not compare a facility's performance to the state average and did not use a statistical distribution.

For the **type of payment structure**, we scored the VBP program as "0," or not in alignment with the recommendation when it used a binary payment structure. Programs scored as "2," or fully in alignment with the recommendation, used a tiered payment system or another type of incentive structure that operated on a sliding scale to reward facilities based on how close they came to meeting the measure(s).

For the **simplicity of its incentive structure**, we assessed the VBP program qualitatively



based on the number of measures and the clarity with which the performance assessment and payment structures were documented. Programs that were scored as “0,” or not aligned with the recommendation, were characterized by the following: many measures, performance assessment and incentive structures that were difficult to understand. Programs scored as “1,” or partially in alignment with the recommendation, were documented well but had many measures and/or had a complicated performance assessment and incentive structure. Programs scored as “2,” or fully in alignment with the recommendation, had a reasonable number of measures (between 6 and 10 measures) and clearly documented performance assessment and incentive structures.

Finally, based on the total points received across all four themes, each program received an **overall score**. Programs that received 7 or 8 points were categorized as “fully or highly aligned,” those with 5 or 6 points were “moderately aligned,” those with 3 or 4 points were “slightly aligned,” and those with 0 to 2 points were “not aligned” with recommendations.

## Results

We identified 30 Medicaid VBP programs across 24 states (Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, New Mexico, New York, Ohio, Oklahoma, Tennessee, Texas, Utah, and Washington). The features of each state Medicaid VBP programs for nursing homes are provide in Appendix 4. The programs varied widely in their design.

### **Program Establishment and Funding**

Approximately two-thirds (66.7%) of programs established their program through statute, 17% were established by a regulation, and for the remaining 16% we could not determine how the program was established. The majority of Medicaid VBP programs were funded by state and federal funds (63.3%), while 33.3% of programs were funded by state and federal funds supplemented with a provider tax, Table 2. We could not determine how many relied on a withhold or carve out of existing funds to create the incentive pool.

<b>Table 2. Program Establishment and Funding (N=30 programs)</b>	
<b>Characteristics</b>	<b>Frequency</b>
<b>Program Establishment</b>	
Statute	66.7% (20)
Regulation	16.7% (5)
Not specified	16.7% (5)
<b>Funding Mechanism</b>	
State & Federal Funds	63.3% (19)
State & Federal Funds, Supplemented with a Provider Tax	33.3% (10)
Not specified	3.3% (1)

### **Performance Measures**

We observed a wide variety in the number and type of performance measures used across all programs. An average of 8 measures were used, with a range of 1 to 37 measures. Table 3 summarizes the number of measures from each program classified into four types of quality measures: structural measures, process measures, outcome measures, and cost and resource measures. Appendix 2 provides a more detailed listing of each specific measure focus used in of each VBP program.

**Table 3. Number of Performance Measures for Each VBP program**

State	Program	Structure	Process	Outcome	Cost & Resource	Total
AZ	DAP	0	0	2	0	2
CA	QASPP	1	4	7	0	12
CO	NFP4PP	9	14	1	1	25
DE	DMVBVP	0	3	3	0	6
FL	PPS	3	6	5	0	14
GA	NHQI	3	2	5	0	10
HI	NFP4PP	1	1	4	0	6
ID	NFQPP	0	3	7	0	10
IN	IMVBPP	1	5	6	0	12
KS	NFQEIF	4	0	0	1	5
KS	CC/PCCIP	0	0	0	0	0
KS	NFMHQEIF	3	0	0	2	5
MD	P4P	5	3	11	0	19
MA	MQI	0	4	0	0	4
MI	NFQMI	0	1	1	2	4
MI	VBR	0	2	6	0	8
MI	QIIP	0	0	0	0	0
NE	NHPP	0	1	0	0	1
NJ	NJQIPP	0	3	3	0	6
NM	HCQSPP	0	2	2	0	4
NM	NFVBPP	0	1	3	0	4
NY	NYSMVBP	0	15	21	1	37
OH	NFMDQIPP	1	0	6	0	7
OK	P4PLTC	0	1	3	0	4
TN	NFPR	6	6	2	0	14
TX	QIIP	4	2	3	0	9
UT	QII1	1	2	0	0	3
UT	QII2	10	2	0	0	12
UT	QII3	0	3	0	0	3
WA	SNFMRS	0	0	4	0	4

### Performance Assessment

We observed multiple trends on how VBP programs assessed performance (Table 4). Most programs (56.7%) converted performance into points. Within a set of measures, a certain number of points was assigned to each measure. For example, Georgia’s program has 10 performance measures, each worth 1 point. Other states assigned a varying number of points to each measure to weight some more heavily than others. Although some programs (23.3%) used a pass/fail system for assessing performance, most programs (53.3%) used an ordinal system. For example, New Mexico's Health Care Quality Surcharge Payment Program assigned a unique number of points (i.e., 20, 40, 60, 80 or 100 points) on each measure in the program based on the providers’ measure performance falling into five categories. In the case of assessing performance for the influenza vaccination measure, New Mexico facilities that achieve a resident vaccination rate of 0%–7.05% were assigned 20 points, 87.06%–94.45%



were assigned 40 points, 94.46%–96.45% were assigned 60 points, 96.46%–99.05% were assigned 80 points, and finally, facilities with resident vaccination rates 99.06%–100% were assigned 100 points.

Approximately a third of programs (40.0%) compared a facility’s results on a measure to the state average. The majority (83.3%) did not use a statistical distribution to assess performance, one state (3.3%) used deciles to assess performance, and the remainder did not specify (13.3%). In assessing performance using a statistical distribution such as quartiles, facilities are ranked against one another with a set of moving targets, rather than against a fixed performance threshold. About one sixth (16.7%) of the programs used the CMS Five-Star program thresholds when measures utilized in the programs were the same as those publicly reported in the Care Compare for Nursing Homes.

While some programs disqualified facilities from receiving payment for the measure if there was any missing data, other programs imputed the missing score using the state average (20.0%) or the facility’s 5-star quality rating performance (3.3%). These seven programs used this imputed data to either assign the facility points for the missing quality measures or used it to assign the facility directly to a payment tier.

Often states used some combination of approaches to setting targets for each measure. For example, two of Hawaii’s performance measures used quintiles from the national distribution to convert measure performance into points. For these two measures, Hawaii’s program considered performing above the national average as an indication of high-quality care. For instance, facilities performing 1 standard deviation (SD) above the national average received 100 points, those 0.5 SDs above the national average received 80 points, those performing within ± 0.5 SDs of the national average received 60 points, those performing 0.75 SDs below than the national average received 40 points, and those performing more than 0.75 SDs below than the national average received 0 points.

<b>Table 4. Performance Assessment (N=30 programs)</b>	
<b>Characteristics</b>	<b>Frequency</b>
<b>Points Assigned to Measure(s)</b>	
Yes	56.7% (17)
No	33.3% (10)
Not specified	10.0% (3)
<b>Rating Type</b>	
Pass/Fail	23.3% (7)
Ordinal	53.3% (16)
Other	6.7% (2)
Not specified	16.7% (5)
<b>Compared to State Average</b>	
Yes	40.0% (12)
No	50.0% (15)
Not specified	10.0% (3)
<b>Used Statistical Distribution (e.g., Quartiles)</b>	
Yes	3.3% (1)
No	83.3% (25)
Not specified	13.3% (4)
<b>Used CMS to 5-Star Thresholds</b>	
Yes	16.7% (5)
No	70.0% (21)
Not specified	13.3% (4)
<b>Specified Plan for Missing Data</b>	
Yes	80.0% (24)
No	20.0% (6)
<b>Specified Frequency of Performance Thresholds Adjustment</b>	
Yes	93.3% (28)
No	6.7% (2)

## Link to Payment

When linking performance to payment, 26.7% of programs assigned a payment amount for each individual measure and 63.3% of programs assigned payment to the aggregate of the measures. In 10% of programs (n=3), we could not determine how payment was linked to performance. Of the programs that used an aggregate score, the majority assigned a varying number of points to each measure to weight some more heavily, while the remaining programs weighted all measures equally. For example, California’s program contains 11 measures adding up to 100 total points, but the individual measures’ maximum assigned points is either 5.56 or 11.11 points. Therefore, performance on certain measures has a larger impact on the facility’s score than other measures. Georgia’s program, by contrast, has 10 performance measures that are all worth up to 1 point, for a maximum total of 10 points.

Next, the majority of programs used a tiered payment structure (53.3%), while the remaining programs used a binary or other type of payment structure. Some programs designed a multi-tiered or binary payment structure for the aggregate performance of all measures, while other programs designed a multi-tiered or binary payment structure for performance of each individual measure. Programs with a tiered payment system used between 3 and 6 tiers. All programs that specified their payment structure (80.0%) linked payment to the number of Medicaid beneficiaries per day at the facility, thereby creating a per day Medicaid incentive. Several types of payment were implemented across the VBP programs. Incentive payments were designed to be a percentage adjustment to the per diem rate or a percentage was withheld from the per diem payment and then redistributed through various methods (36.7%), or additional funds were distributed through various methods on top of the per diem payment (43.3%). Finally, only 40% of programs specified a plan for adjusting payment structure over time. Refer to Table 5 for more information about Medicaid value-based payment program incentive structure.

<b>Table 5. Link to Payment (n=30 programs)</b>	
<b>Characteristics</b>	<b>Frequency</b>
<b>Payment Link to Measures</b>	
Individual	26.7% (8)
Aggregate	63.3% (19)
Not specified	10.0% (3)
<b>Type of Payment: Binary or Tiered</b>	
Binary	20.0% (6)
Tiered	50.0% (15)
Other	16.7% (5)
Not specified	13.3% (4)
<b>Number of Tiers (n=16 programs)</b>	
Average	4.1
Range	3, 6
<b>Type of Payment</b>	
Withhold a Percentage of per Diem Payments or Percentage Adjustment to the per Diem Rate, then Redistribute through Various Methods	36.7% (11)
Additional Funds are Distributed through Various Methods on Top of per Diem Payments	43.3% (13)
Not specified	20.0% (6)
<b>Payment Structure Adjusted Over Time</b>	
Yes	40.0% (12)
No	6.7% (2)
Not specified	53.3% (16)
<b>Payment Linked to Medicaid Beneficiaries/Days</b>	
Yes	80.0% (24)
No	0.0% (0)
Not specified	20.0% (6)

Almost all the programs (90.0%) specified how frequently performance thresholds and performance conversion to points can be adjusted. While some programs allowed for adjustment to the thresholds at the end of every fiscal year, half of the programs only allowed adjustments during rebasing years, which typically occurred every three or five years. Refer to Table 4 for more information about Medicaid VBP program performance assessment.

### Comparison of Program Features Against Best Practices

We compared each program on its predictability and consistency, use of a stable performance benchmark, type payment structure, simplicity of incentive structure, and assigned an overall rating. Overall, we found that many programs are not in alignment with the recommend best practices. Only 4 programs were “fully or highly aligned” with the recommendations (e.g., had a total score of 7 or 8), 12 programs were “moderately aligned,” 7 programs were “slightly aligned,” and 5 programs were “not aligned” with these recommendations.

State	Program	Predictable & Consistent	Stable Benchmark	Tiered Payment Structure	Simple Incentive Structure	Overall Rating <sup>1</sup>
AZ	Differential Adjusted Payments	0	0	0	1	Not aligned
CA	Quality and Accountability Supplemental Payment Program	0	0	2	2	Slightly aligned
CO	Nursing Facility Pay for Performance Program	0	2	2	2	Moderately aligned
FL	Prospective Payment System	2	0	2	1	Moderately aligned
GA	Nursing Home Quality Initiative: Aged, Blind, and Disabled	0	M	2	1	Slightly aligned
HI	Nursing Facility Pay for Performance Program	2	0	2	1	Moderately aligned
ID	Nursing Facility Quality Payment Program	2	1 <sup>2</sup>	2	1	Moderately aligned
IN	Indiana Medicaid Value Based Purchasing Program	1	0	2	1	Slightly aligned
KS	Nursing Facility Quality and Efficiency Incentive Factor	0	0	0	1	Not aligned

<sup>1</sup> Based on the total points received across all four measures, each program received an overall rating. Programs that received 7 or 8 points were “fully or highly aligned,” those with 5 or 6 points were “moderately aligned,” those with 3 or 4 points were “slightly aligned,” and those with 0 to 2 points were “not aligned.”

<sup>2</sup> Idaho’s program was scored as “1,” or partially in alignment with the recommendation, because the state averages are only used on rebasing years (every 5 years) to redefine the benchmarks.

Table 6. Comparison of Selected Program Components to Recommendations from the Literature						
State	Program	Predictable & Consistent	Stable Benchmark	Tiered Payment Structure	Simple Incentive Structure	Overall Rating <sup>1</sup>
KS	The Culture Change/Person-Centered Care Incentive Program	0	2	2	2	Moderately aligned
KS	Nursing Facility for Mental Health Quality and Efficiency Incentive Factor	0	2	2	1	Moderately aligned
MD	Pay for Performance	1	2	M	1	Slightly aligned
MA	Medicaid Quality Incentive	0	2	2	2	Moderately aligned
MI	Nursing Facility Quality Measure Initiative	M	2	2	2	Moderately aligned
MN	Value Based Reimbursement	1	2	2	2	Fully or highly aligned
MN	Quality Improvement Incentive Program	1	2	2	2	Fully or highly aligned
NE	Nursing Home Payment Project	0	2	2	2	Moderately aligned
NJ	New Jersey Quality Incentive Payment Program	0	0	0	1	Not aligned
NM	Health Care Quality Surcharge Payment Program	2	2	2	2	Fully or highly aligned
NM	Nursing Facility Value Based Payment Program	2	2	2	2	Fully or highly aligned
OH	Nursing Facility's per Medicaid Day Quality Incentive Payment Rate	1	0	2	1	Slightly aligned
OK	Pay for Performance in Long Term Care	1	2	0	2	Moderately aligned
TN	Nursing Facility Provider Reimbursement	2	2	2	0	Moderately aligned
TX	Quality Incentive Payment Program	2	2	0	0	Slightly aligned
UT	Quality Improvement Incentive 1	0	2	M	0	Not aligned
UT	Quality Improvement Incentive 2	0	2	0	2	Slightly aligned
UT	Quality Improvement Incentive 3	0	M	M	0	Not aligned
WA	Skilled Nursing Facility Medicaid Reimbursement System	0	2	2	2	Moderately aligned

## Discussion

We identified 30 nursing facility Medicaid value-based payment programs currently used by 24 states. This represents more than double the number of Medicaid VBP program identified in the last national survey of state programs in 2008 (i.e., 9 states with a program and 5 states considering implementation of VBP programs).<sup>22</sup> Overall, we found wide variation in design features. Although some of this variation can allow for an effective program, not all program features align with the best practices we identified from previous VBP literature and program evaluations across different care settings and insurances (see Table 1). As States consider developing or updating their VBP program because of CMS's State Medicaid Director guidance, we identified additional features that can help make for a more successful VBP program (see Table 7).

### ***Program Establishment and Funding***

Funding source serves as the basis of any Medicaid VBP program and should be carefully considered. Two distinguishing features can significantly impact the effect of a VBP program: the establishment of the funding mechanisms (i.e., additional funds, carve out of existing funds) and the size of overall funds and therefore the size of the incentive pool. If the funding mechanism is carved out of existing funds, the size of the carve out has the potential for deleterious impacts on revenue and unintendedly may result in fewer resources and worsened quality among the lowest performing or financially stressed providers. Additionally, if not all the funds from the incentive pool are distributed (i.e., remains at least budget neutral), then the program may unintentionally result in payment cuts.

Furthermore, the incentive needs to be large enough to facilitate investments in higher quality outcomes.<sup>11</sup> It was outside the scope of our review to determine whether the size of the incentive pool or the VBP payment of the programs reviewed was sufficient to change practices. However, in our review we came across states that had taken such investments into account in their programs. For example, Utah's Quality Incentive Improvement Program 2 offered an incentive for investments in patient life-enhancing improvements such as wander management systems, fall-reducing beds, exercise equipment, and more. Additionally, one of Minnesota's programs allowed for upfront payments to support quality improvement efforts.

Evidence from CMS's Medicare VBP program for Skilled Nursing Facility (SNF) underscores the impact of the incentive pool creation on a program's success. The Medicare VBP program for nursing homes rolled out in fiscal year 2019 and linked 2% of SNF Part A Medicare payment to the SNF 30-day readmission rate.<sup>26,27</sup> An evaluation of this program found only a minimal change in rehospitalization rates but a redistribution of payments. On average this redistribution resulted in payment cuts, and it was observed that the payment cut was larger among facilities serving residents in low-income communities and among those serving a higher proportion of frail residents.<sup>28</sup> Specifically, the average payment adjustment resulted in a cut of 0.84% and nearly three quarters of SNFs (72%) received a payment cut, however, the top performing providers saw up to a 1.65% increase in their Medicare payments.<sup>28</sup> The overall program design can explain this finding. The Medicare SNF VBP program applies a 2% withhold to the SNF Part A Medicare payments but uses only 60% of this withhold as the incentive pool.<sup>26</sup> Overall, this results in a 40% reduction. A more recent evaluation found that SNFs with the worst financial condition were more likely to receive larger cuts under this program.<sup>29</sup> These findings highlight concerns that depending on the incentive pool creation, VBP programs may result in taking resources away from providers with poor financial status.



Establishing new and multi-year sustainable funds for a Medicaid VBP program can be challenging for states. Many early Medicaid nursing home VBP programs lasted solely a few years,<sup>15</sup> often due to loss of funding source supporting the incentive payment.<sup>14</sup> This has led to some programs relying on existing funds by applying a withhold to payments to create the incentive pool. However, at the provider level, this can have the unintended effect of resulting in payments cuts which can create a disincentive for performance improvement, particularly in cases where the costs to improve exceeds the cut that would arise with failure to achieve the target. The marginal cost of improvement relative to the incentive size is cited as a factor associated with Medicaid SNF VBP programs' ineffectiveness.<sup>11,30</sup> In our review of the programs, we were unable to determine whether the funding source used to create the incentive pool stemmed from withholds.

Regardless of the funding source, states need to be transparent on the source and take into consideration how the source impacts ongoing stability of the program and how it impacts the size of the incentive or payment adjustment at the provider level. We found that the funding for most programs was complex, and the transparency was poor; it was challenging to determine the source of funding and the size of the budget for many programs.

## **Performance Measures**

Programs should select a reasonable number of measures that represent meaningful aspects of care.<sup>11</sup> Evaluations of prior nursing home Medicaid VBP programs from 1980 to 2007<sup>15,31</sup> found measures range from clinical outcome and process measures to structural, regulatory compliance, and other reporting information. Given the size of most nursing home populations, to ensure reliability in measurement, most measures in use often span wide time frames (i.e., 12 months). Since many VBP programs evaluate performance on an annual basis, if this timeline is not in alignment with that of the measures used, it can be hard for providers to achieve targets in the time window specified by the VBP program. Furthermore, careful consideration should be given to the timing needed to implement meaningful changes in structure or practice to achieve performance benchmarks. Additionally, some metrics are calculated using claims or other administrative data whose delays in processing and publication time can cause measure results, and therefore payments, to be available long after any change in provider behavior.

Like prior studies,<sup>22</sup> we found wide variation in measures used in nursing home Medicaid VBP programs. Among available programs, the number of measures ranged from 1 to 37 and averaged 8 measures. To our knowledge, there is no recommendation in literature on the ideal number of measures to use in such programs, however, too few or too many measures will impact how providers respond to VBP programs.<sup>21</sup> If the program contains too few measures it may not capture sufficient domains of the quality of care being delivered at the facility, while containing too many measures may overwhelm facilities' capacities for performance improvement. For example, inclusion of more than 10 measures may dilute the impact of each measure, while inclusion of one or two measures does not allow for broader performance improvement often desired by policymakers. Furthermore, selecting measures that have the greatest impact on a large proportion of beneficiaries' outcomes and quality of life should be considered, especially measures that require and reflect systematic changes in practice. Inclusion of such measures has the potential to positively impact performance on other metrics. For example, performance improvements on hospitalization measures require improvement in numerous clinical areas and systems, whereas performance improvements on urinary incontinence measure can be achieved by solely focusing on the diagnosis and prevention of urinary incontinence.



## ***Performance Assessment***

We observed great variation in how programs assessed performance. Most programs used some comparison of providers' performance against each other. This type of performance assessment can shift as the group's overall performance shifts over time. For example, we found one-third of programs used their state average as the performance threshold. The state average is a moving target that can penalize lower-performing facilities for performing below their peers despite making clinically meaningful improvements in quality. This becomes even more apparent in states where most of the facilities in the program exhibit some improvement. For the same reasons, programs should also avoid using solely a statistical distribution (e.g., quartiles) but should opt for statistically and clinically meaningful benchmarks. In cases where Medicaid VBP programs use publicly reported measures such as those in the Nursing Home Care Compare Five-Star, programs should consider using the same Five-Star performance thresholds to reduce administrative burden.

Many programs assigned points to each measure based on achieving predetermined benchmarks. Setting predetermined benchmarks necessary to achieve VBP payments is more effective at improving quality, particularly among the lowest performing providers.<sup>20</sup> In our evaluation of existing Medicaid VBP programs, we found that some used a threshold approach (i.e., the CMS thresholds used in Five Star) but often the achievement targets were established after the program launch. When the targets for achievement are unknown, providers are reluctant to invest in changes needed to improve on the metrics, especially if the cost of investment may exceed the VBP payment amount.<sup>15,32,33</sup>

Furthermore, the contribution of a given measure on the overall program performance varied. Some states assigned equal weight or importance to all the measures in the program, while others assigned greater importance to some measures. Weighting measures different amounts on the overall performance has been found to focus providers' efforts on higher weighted measures.<sup>34</sup>

It is unclear whether improvement should be factored in performance assessment. Some worry that without improvement factored into the performance assessment, the lowest performing facilities will be left behind.<sup>14</sup> Congress specifically requires improvement be considered in the SNF Medicare VBP program.<sup>27</sup> However, contrary to economic theory, several studies in hospitals, physician practices, and nursing homes have found that generally providers with the lowest performance improve the most in VBP programs.<sup>20,35</sup> The lowest performing facilities are the ones that demonstrate the greatest improvement when established benchmarks are predetermined,<sup>20</sup> as long as the targets are achievable.<sup>19</sup>

Finally, programs had varying strategies for how to address facilities with missing data on one or more performance measures in the VBP program. Some programs imputed data, usually using the state average for the missing metric, while others disallowed payment for that measure especially in cases when payment was linked to individual measure performance. It was unclear from many states' documents how data missing for one or metrics was handled. Therefore, states need to develop a plan for how to address facilities that may have missing data for one or more measures.

## ***Link to Payment***

A key feature for successful Medicaid pay-for-performance programs is linking the incentive amount with specific performance targets.<sup>20</sup> Nursing home Medicaid VBP programs varied in how they paid for performance, ranging from a bonus or add-on to the nursing home's per diem rate to percentage adjustment of the facility's Medicaid per diem rate. This variation has been

found in programs in other settings.<sup>36</sup> We are not aware of research in the long-term care or other settings to determine the most effective payment method. Previous evidence has found that the frequency of payment (i.e., quarterly vs. annually) in a physician-specific VBP program did not affect quality measure performance, however the incentive payments used in the study were small which could have impacted the observed results in this program.<sup>37</sup>

When designing a program, states should consider including a tiered payment system that delivers different levels of payment based on the facilities performance achievement.<sup>7,10</sup> This is particularly important when the payment source is carved out of existing payments such as a withhold, so that lower performing providers don't receive large unsustainable cuts. Overall, programs should keep their incentive structure simple and carefully consider how many payment tiers are implemented. While the use of payment tiers introduces nuance, too many payment tiers could cause confusion with little added value. Furthermore, the payments associated with performance need to be predictable, achievable, and large enough to incentivize performance improvements.<sup>31</sup>

Although the goal of this study was not to determine the minimum effective payment size, we noted variation in the design of the payment structure. Some programs withheld a percentage of the per diem or conducted a percentage adjustment to the per diem rate, then redistributed the incentives through various methods. Other programs distributed additional funds on top of the per diem rate using different mechanisms. Both methods are reasonable approaches if the size of the incentive and the specific targets on the measures are clearly delineated at the beginning of the performance period.

### ***Frequency of Updates***

In general, programs should strive for predictability and consistency. Some programs allow for annual adjustments to program components, such as performance measures and payment structure, while others only allow adjustments to be made during rebasing years. The frequency of rebasing years ranged from 2 to 5 years. When program features change year to year, such that the measures or performance targets or payment amounts are unknown, providers may be reluctant to make investments that may take greater than 12 months to produce the desired results. Adjustments should be limited to pre-established rebasing years, which should occur at least every 2 years, because facilities will have enough time to improve performance after adjustments are made.

### ***Medicaid Managed Care VBP***

We found that two states – Delaware and New York – left most, if not all, program components to the discretion of the Managed Care Organizations (MCOs). Delaware prescribed performance measures and thresholds and the MCOs dictated eligibility criteria, additional performance assessment details, and the link to payment. By contrast, New York recommended a large set of measures, but all program components are dictated by the MCOs. MCOs can play a key role in the success of a VBP program, but they should be held accountable to program best practices. Furthermore, states should provide some oversight and guidance to ensure that the MCOs' VBP programs are successful.

### ***Program Transparency***

Finally, it is essential that programs transparently document all specifications of the program thoroughly. In our review, two thirds of the programs were established through statute, containing legalese and technical jargon, which make it difficult for providers to understand. Programs should make additional efforts to document their program in lay and transparent language. For example, programs such as Hawaii's VBP program had transparent and

straightforward documentation and can serve as a standard framework for states that update or design a new VBP program.

Table 7. Key Recommendations for a Successful Medicaid VBP Program	
Category	Recommendation
Funding	Be at least budget neutral.
	Avoid using an unstable or non-sustainable funding source for incentive pool.
Performance Assessment	Compare performance to a set benchmarks or clinically meaningful thresholds
	Address clinically relevant aspects of nursing facility care
	Avoid comparing performance to the state average or using a statistical distribution
	Specify how payment will be affected when a facility is missing data on a measure.
	Select a reasonable number of measures that represent key aspects of care.
Link to Payment	Offer an incentive large enough to enable facilities to invest in redesigning care and improving quality
	Create a simple incentive structure
	Create a tiered payment structure
	Quality incentives should be designed as a percentage adjustment to the facility's per diem rate.
General	Be predictable and consistent.
	Avoid frequent adjustments (e.g., annually) to program components, such as performance measures and payment structure.
	Thoroughly document program components in clear language.

### Limitations

This review has a few limitations. First, we may not have identified all the VBP programs available despite our outreach efforts to every state. We also may not have had access to all documents explaining the program and therefore missed some features. However, our multi-pronged approach to obtain documents from each state should be able to capture the extent of the information available and further underscores our recommendation to make the program features transparent and easily accessible.

Second, we made several recommendations given the relatively limited research in this area. Our recommendations are supported principally only by face validity and not quantitative analyses. Third, our analyses summarize and describe the state nursing home Medicaid VBP programs, but do not analyze the effectiveness of any program or their components.

Fourth, we could not analyze the extent to which some of the best practices identified in the literature were implemented in each program. For example, we did not assess the budget neutrality of each program because this information could not be gleaned from the information that was publicly available or provided by state affiliates for most programs. We also did not assess whether the measures were clinically relevant and appropriate for the beneficiary population or if the incentives were large enough because it was outside the scope of this study to determine the effectiveness of such program components. Fifth, we were not able to assess stakeholder input in the design of the programs. Engagement and involvement of providers as well as consumers has been identified as key to the success of Medicaid nursing home VBP programs.<sup>6,14,38</sup>

Finally, Delaware and New York's programs relied primarily on the MCOs to define the details of

their VBP arrangements in contracts with providers. The structure of our review was better suited to programs that are defined and implemented through the state, rather than MCOs. As such, we could not compare Delaware and New York's programs to the best practices from the literature.

Despite these limitations, we believe we completed an effective environmental scan of all current Medicaid VBP programs. Our categorization of program components and presentation of recommendations are a resource that can be used by states that seek to develop or update Medicaid VBP programs.

## ***Impact of VBP Programs on Outcomes***

Generally, most evaluations assessing the effectiveness of VBP programs have been undertaken in the hospital or physician setting and found improvements in quality to be mixed or small.<sup>39,40</sup> To date, two studies have evaluated the impact of SNF Medicare VBP program finding small or insignificant changes in outcomes.<sup>28,41</sup> Specifically, one of the evaluations of the SNF Medicare VBP program, using data from the demonstration period in three states, found no appreciable impact on rehospitalization rates or Medicare spending.<sup>41</sup> The authors attributed the lack of change to the program design that based the incentive pool on shared savings which created uncertainty among the providers about the incentive size.

Evaluations of nursing home Medicaid VBP programs have shown mixed results.<sup>30,34,42</sup> We found one nursing homes VBP randomized controlled trial in published in 1992 which noted "beneficial effects on both quality and cost of nursing home care".<sup>42</sup> Since then, several evaluations of nursing home Medicaid VBP programs have generally found mixed results, often finding insubstantial or unsustainable improvements.<sup>13,14,30,43</sup> An eight state evaluation found inconsistent quality improvement, potentially attributable to the small incentive size that often did not exceed the marginal cost of improvement.<sup>30</sup> A review of 22 different VBP programs, including Medicaid nursing home programs from 2002 to 2012, found that VBP can lead to improvements for some performance metrics when the program is "properly designed and implemented".<sup>38</sup> Ideally VBP programs should be coupled with other quality improvement efforts and aligned with other public policy efforts such as public reporting.<sup>38</sup>

Despite the growth in Medicaid VBP programs in long-term care, to our knowledge, there have been no systematic reviews of their impact on quality or cost since 2016. Additional research needs to be conducted to empirically assess the effectiveness of programs currently in use.

## **Policy Implications**

As a result of CMS's State Medicaid Directors Letter, value-based payment programs will continue to expand and evolve. Because the CMS guidance was not prescriptive in the design features of a VBP program, states have the freedom to design a program that will best serve their unique population. However, they also should be mindful to consider incorporating features that will make the VBP program successful, as this has the propensity to translate to greater gains in their payments in the form of improving residents' clinical outcomes and quality of life. This study sought to provide information on key features of existing nursing home Medicaid VBP programs as compared to best practices identified from other pay for performance programs. State Medicaid officials that seek to design new VBP programs may benefit from the information in this review. More research is needed to determine the features with the greatest impact on providers as well as on beneficiary's outcomes. Given the gap in this research, state Medicaid officials should also consider designing plans to evaluate the effectiveness of their program components.

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## Appendix 1: Detailed List of Variables

Category	Variable
Program Establishment and Funding	Effective date of program
	Was the program established through statute or regulation?
	Link to statute or regulation
	Funding mechanism <sup>3</sup>
	Funding notes
	Size of program budget
	Is the budget adjusted over time?
Performance Measures and Performance Assessment	Budget adjustment notes
	Are points assigned to each measure? <sup>4</sup>
	Are the measures rated on a pass/fail or ordinal scale? <sup>5</sup>
	Is each facility's score compared to the state average?
	Are the facilities compared to a statistical distribution? <sup>6</sup>
	Are facilities compared to 5-star thresholds?
	Number of measures
	Assessment notes
	Specified what to do with missing data?
	Missing data notes
Link to Payment	Specified how often thresholds for performance can be adjusted?
	Frequency of performance threshold adjustment notes
	Is payment tied to individual measures or an aggregate of measures?
	For aggregate scores, how are the measures weighted?
	Are payments binary, tiered, or another type?
	For tiered payments, how many tiers are there?
	Size of payment
	How is the base payment adjusted for the quality incentive? <sup>7</sup>
	Is the payment a flat rate or percentage adjustment to the per diem rate? <sup>8</sup>
	Are these payment thresholds adjusted over time?
How is unused money redistributed?	
Is payment tied to the number of Medicaid beneficiaries/days?	
Payment Notes	

<sup>3</sup> The funding mechanisms were state and federal funds, state and federal funds supplemented with a provider tax, or it was not specified.

<sup>4</sup> Most programs converted performance into points. Within a set of measures, a certain number of points is assigned to each measure. For example, Georgia has 10 performance measures, each worth 1 point. Other states assign a varying number of points to each measure in order to weight some more heavily.

<sup>5</sup> When programs rated performance on an ordinal scale, there were multiple levels at which the facilities' performance could be rated. California's program is one example of this type of rating system. For each measure, facilities that performed better than the 75<sup>th</sup> percentile received the full points for the measure, facilities that performed between the state average and 75<sup>th</sup> percentile received half the points for the measure, and facilities that performed less than the state average received no points for the measure.

<sup>6</sup> Statistical distributions include quartiles, quintiles, and deciles. No other types of statistical distributions were found in any other programs.

<sup>7</sup> Relative to the per diem rate, quality payments were either additive, subtractive, or both were possible.

<sup>8</sup> Some programs deliver the quality incentive as a flat rate increase to the per diem rate. Other programs deliver the quality incentive as a percentage adjustment to the per diem rate. For example, facilities that perform in the highest tier in Georgia receive a 2% adjustment to their per diem rate.



# Appendix 3: State Trade Association Survey Questions

We sent the following Qualtrics survey to AHCA state long-term care (LTC) trade association (each state but MT has an LTC association) to identify which states have a VBP program and to collect information about those programs.

1. State
  - a. [Open text response]
2. Contact Information
  - a. Name
  - b. Title
  - c. Email
3. Does your state link Medicaid payment or other incentive payments with quality (e.g., Value Based Payment, Pay-for-Performance, etc.)?
  - a. Yes
  - b. No
4. Has your state *made any changes to the Medicaid Value Based Payment program since 2016?*
  - a. Yes
  - b. No
5. Please provide any links to statutes, regulations, or any other information you want to share.
  - a. [Open text response]
6. Please attach documents that describe your state's VBP program(s) (such as PowerPoints, PDFs, etc.).
  - a. [File upload]

## Appendix 4: Individual State Medicaid Value Based Payment Program Summaries

### Arizona

#### *Differential Adjusted Payments*

##### **Program Establishment and Funding**

Arizona's Medicaid VBP program, established through [regulation](#), was revised effective October 1, 2020. The program is funded by state and federal funds. The budget is approximately \$6 million and is adjusted annually through the state budget process with the Arizona Health Care Cost Containment System.

##### **Eligibility Criteria**

These following providers are eligible: Hospitals Subject to APR-DRG Reimbursement, excluding Critical Access Hospitals; Critical Access Hospitals; Other Hospitals and Inpatient Facilities; IHS and 638 Tribally Owned and/or Operated Facilities; Nursing Facilities; Integrated Clinics; Behavioral Health Outpatient Clinics; Behavioral Health Outpatient Clinics and Integrated Clinics; Physicians, Physician Assistants, and Registered Nurse Practitioners; Dental Providers; Home and Community Based Services Providers.

##### **Performance Measures**

The DAP assesses performance for skilled nursing facilities on 2 measures:

- Pressure Ulcer Performance Measure
- Urinary Tract Infection Performance Measure

##### **Performance Assessment**

Points are assigned to each measure and performance is rated on a pass/fail scale. Measures are based on CMS Quality Measures because they are a national standard with documented integrity, and they do not require duplicative reporting. If facilities are missing data, they become ineligible.

##### **Link to Payment**

Facilities receive payment based on their performance on individual measures. Payment is received in the form of additive adjustments to the per diem rate of 1.0% for each measure.

## California

### Quality and Accountability Supplemental Payment Program

#### Program Establishment and Funding

California’s Medicaid VBP Program was established through statute effective August 1, 2011. The program is funded by state and federal funds. The size of the budget varies from year to year.

#### Eligibility Criteria

Skilled nursing facilities are ineligible for payment in the following scenarios: the facility does not meet the staffing ratio for 1 or more days in the performance period, the facility receives an A or AA citation during the performance period, the facility has less than 90% data completeness, or 0 Medi-Cal FFS days were included in the audit period.

#### Performance Measures

The QASP Program assesses performance on 11 quality measures:

- Pressure Ulcers: Long Stay
- Physical Restraints: Long Stay
- Influenza Vaccine: Short Stay
- Pneumococcal Vaccine: Short Stay
- UTI: Long Stay
- Control of Bowel/Bladder: Long Stay
- Pain: Short Stay
- Pain: Long Stay
- ADL Decline: Long Stay
- Staff Retention
- 30-Day All Cause Readmission
- CA Antipsychotic Medication

#### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. Each facility’s performance is compared to the state average using the following scoring methodology: facilities that perform better than the 75<sup>th</sup> percentile receive full points, facilities that perform between the state average and the 75<sup>th</sup> percentile receive half the points, and facilities that perform below the state average receive no points.

#### Link to Payment

Facilities receive payment based on their aggregate score from all performance measures. Some measures are weighted to have a greater impact on the score. There are three payments tiers which either award a flat increase to the per diem rate or no payment. The top 10% of facilities who improved from the previous year are also awarded the QASP Improvement Payment (\$2 per Medi-Cal Bed Day).

Tier	Points	2014 Payment
1	0 – 49.9999	\$0 per Medi-Cal FFS and Managed Care Bed Days
2	50 – 66.6699	\$8 - \$10 per Medi-Cal FFS and Managed Care Bed Days
3	66.6700 – 100	\$13 - \$15 per Medi-Cal FFS and Managed Care Bed Days



## Colorado

### *Nursing Facility Pay for Performance Program*

#### Program Establishment and Funding

Colorado’s program, established through [statute](#), became effective on July 1, 2009. The program is funded through a state and federal funds supplemented with a provider tax. In the last two fiscal years, total payments have averaged \$9 million.

#### Eligibility Criteria

All facilities are eligible if they perform a resident/family satisfaction survey and do not have any substandard deficiencies on any CDPHE survey.

#### Performance Measures

Colorado assesses performance on 23 quality measures:

- Enhanced Dining
- Enhanced Personal Care
- End of Life Program
- Connection and Meaning
- Person-Directed Care Training
- Trauma – Informed Care
- Daily Schedules and Care Planning
- Physical Environment – Appearance
- Physical Environment – Noise Management
- QAPI
- Consistent Assignments
- Volunteer Program
- Staff Engagement
- Transition of Care – Admissions, Transfer and Discharge Rights
- Vaccination Data
- Reducing Avoidable Hospitalizations
- Nationally Reported Quality Measures Scores
- Best Practices
- Antibiotics Stewardship/Infection Prevention & Control – Documentation
- Antibiotics Stewardship/Infection Prevention & Control – Quality Measures
- Medicaid Occupancy Average
- Staff Retention Rate/Improvement
- DON and NHA Retention
- Nursing Staff Turnover Rate
- Behavioral Health Care

#### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. This program does not use a statistical distribution or compare performance to the state average. The pay for performance program is evaluated annually by a committee consisting of Nursing Facility stakeholders, Colorado Health Care Association, and State Health Care Policy and Financing personnel.

#### Link to Payment

Facilities receive payment based on their aggregate score from all performance measures. There are 5 payment tiers. Some measures are weighted more heavily than others.

Tier	Points Earned	Per Day Add-On
1	0-20	\$0.00
2	21-45	\$1.00
3	46-60	\$2.00
4	61-79	\$3.00
5	80-100	\$4.00

## Delaware

### *Delaware Medicaid Value-Based Purchasing*

#### **Program Establishment and Funding**

Delaware's Medicaid VBP Program, established through [statute](#), became effective on January 1, 2018. The program is funded through state and federal funds supplemented with a provider tax. Delaware's program is relatively unique because many of the program features are left to discretion of the two Medicaid Managed Care Organizations (MCOs) to design and implement.

#### **Eligibility Criteria**

The Medicaid MCOs are responsible for determining eligibility criteria; none are required by the program.

#### **Performance Measures**

Delaware assesses performance on 6 quality measures:

- Comprehensive Diabetes Care
- Medication Management for People with Asthma
- Cervical Cancer Screening
- Breast Cancer Screening
- Adult Body Mass Index Assessment
- 30-Day Hospital Readmission Rate

#### **Performance Assessment**

Points are assigned to each measure and performance is evaluated on a pass/fail basis. The performance threshold for each measure is the state average. The seven measures include a mixture of structure, process, and outcome measures covering a range of chronic disease management, preventive care, and acute care. They were selected based on a combination of measurability, impact, historical performance, and populations affected. The MCOs may specify additional details of performance assessment in their contracts with providers.

#### **Link to Payment**

The initial measurement period for the program was calendar year 2018, but it was considered the baseline year with no potential financial penalties. In future years, the financial penalty is a maximum of 1% of the total payment. The MCOs must specify all remaining details of how performance is linked to payment in their contracts with providers.

## Florida *Prospective Payment System*

### Program Establishment and Funding

Florida's Medicaid VBP Program, established through [statute](#), became effective on October 1, 2018. The program is funded through state and federal funds. Currently, the VBP program uses 6% of the state's Medicaid budget.

### Eligibility Criteria

Skilled nursing facilities are eligible if they are not government-owned and if they complete the CDPHE survey.

### Performance Measures

Florida assesses performance on 14 quality measures:

- % of long-stay residents assess and appropriately given the seasonal influenza vaccine
- % of long-stay residents who received an antipsychotic medication
- % of long-stay residents who were physically restrained
- % of long-stay residents with a urinary tract infection
- % of high-risk long stay residents with pressure ulcers
- % of long-stay residents experiencing one or more falls with major injury
- % of low risk long-stay residents who lose control of their bowels or bladder
- % of long-stay residents whose need for help with daily activities has increased
- Combined direct care staffing (RN, LPN, CNA)
- Social work and activity staff
- CMS 5-Star rating
- Florida Gold Seal Award
- Joint Commission Accreditation
- AHCA National Quality Award

### Performance Assessment

Points are assigned to each measure. Performance is evaluated on an ordinal basis and is compared to the state distribution. For example, for the QM and staffing-based measures, providers with performance in the 50<sup>th</sup> percentile receive 1 point, those in the 75<sup>th</sup> percentile receive 2 points, and those in the 90<sup>th</sup> percentile receive get 3 points; the more points earned the higher the quality add-on. For new facilities, quality incentive payments will be applied at a value equal to the 50th percentile quality score for Florida Medicaid providers included in the prospective payment methodology. If data is missing because the facility failed to report it, the facility is not eligible for those. The state updates cost-based components every 3 years, whereas the quality provider scores are updated annually.

### Link to Payment

For each measure, a provider is awarded points. Facilities receive payment based on their aggregate score from all performance measures. To qualify for the payment, a provider must score at least at the 20<sup>th</sup> percentile in total points statewide. This leads to some providers receiving no rate add-on. The points are then adjusted based on provider total Medicaid patient days and the resulting adjusted points are used to determine a provider's portion of Quality Incentive funds. The weighted provider score for each qualifying provider is calculated by multiplying the provider quality points by the number of annualized Medicaid days as reported in the most recent cost report received by the rate setting acceptance cut-off date. The payment per quality point is established by dividing the total quality budget by the sum of all weighted provider scores. The per diem quality incentive component is calculated by multiplying a provider's weighted quality score by the payment per quality point.

## Georgia

### *Nursing Home Quality Initiative: Aged, Blind, and Disabled*

#### Program Establishment and Funding

Georgia's Medicaid VBP Program, established through [regulation](#), became effective in April 2007. The program was recently revised, effective July 1, 2020. The program is funded through state and federal funds. The budget for FY2021 is over \$1.3 million.

#### Eligibility Criteria

All skilled nursing facilities are eligible to participate if they participate in the annual satisfaction survey (for residents, families, and employees) and submit monthly quality profile data to NRC.

#### Performance Measures

Georgia assesses performance on 10 quality measures:

- Most Current Family Satisfaction Survey Score for "Would you recommend this facility" % excellence and % good to meet or exceed the state average of 85% combined (participation required to be eligible for the incentive).
- Participation in the Employee Satisfaction Survey
- Quarterly average for RNs/LVNs/LPNs Stability (retention)
- Quarterly average for CNAs /NA Stability (retention)
- 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 Self-Report Moderate to Severe Pain
- Percent of Short-Stay Residents with Pressure Ulcers, New/Worsened
- Percent of Residents Who Received Influenza Vaccine
- Percent of Residents Experiencing One or More Falls with Major Injuries

#### Performance Assessment

Georgia assesses performance on 4 non-clinical and 6 clinical measures, evaluated monthly with a quarterly qualification report submitted by NRC to the Department of Community Health. Facilities must report data from at least two of the three months in the quarter to receive incentive payments. Changes can be made to the program annually.

#### Link to Payment

All 10 measures are weighted equally, and payment is linked to the aggregate score. There are 3 payments tiers, as follows:

- Bronze: add 1% to quality add-on, not exceed a maximum add-on of 2%
- Silver: add 1% to the quality add-on, not to exceed a total quality add-on of 3%
- Gold: add 2% to the quality add-on, not to exceed a total quality add-on of 4%

To qualify for a quality incentive adjustment equal to 1%, the facility must obtain a minimum of 3 points: 1 point must come from clinical measures, one point from the non-clinical measures, and a third point from either category. To qualify for a quality incentive adjustment equal to 2%, the facility must obtain a minimum of 6 points: 3 points must come from the clinical measures, 1 point from the non-clinical measures, and 2 points from either category.

## Hawaii

### *Nursing Facility Pay for Performance Program*

#### Program Establishment and Funding

Hawaii’s Medicaid VBP program, established through [statute](#), became effective on July 1, 2020. The program is funded by a provider tax, which is combined into a total quality pool representing 1% of historical nursing facility Medicaid managed care revenue.

#### Eligibility Criteria

Both private and public nursing facilities will be eligible to receive distributions; there will be separate quality pools for private and public facilities.

#### Performance Measures

Hawaii assesses performance on 6 quality measures:

- Long-Stay Urinary Tract Infection
- Long-Stay Antipsychotic Medications
- Long-Stay Pressure Ulcers
- PointRight Pro 30 – Rehospitalizations
- PointRight Pro Long Stay Hospitalizations
- Bonus points for AHCA/NCAL National Quality Award

#### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. The initial measurement period for the program is calendar year 2020. Measurements will be taken for the full year, even though the program will only be operational for half the year. Facilities with missing data on a measure will receive the state-wide average score for that metric. Performance thresholds will remain constant for the first three years of the program in order to provide facilities with defined targets.

#### Link to Payment

Facilities receive payment based on their aggregate score from all performance measures. There are 4 payment tiers. Payments are based on a percentage of the facility’s total pool. Facilities ranked in Tier 1 or 2 will receive additional distribution of the remaining unearned pool, based on each nursing facility’s earned dollars as a percent of total earned dollars for Tier 1 and Tier 2. The remaining pool is the difference between the total pool and the earned payments.

Tier	Percent of Total Possible Score	Points	Payment
1	90%	≥450	100% of the facility’s pool
2	80%	400-449	90% of the facility’s pool
3	70%	350-399	80% of the facility’s pool
4	<70%	<350	75% of the facility’s pool



## Idaho Nursing Facility Quality Payment Program

### Program Establishment and Funding

Idaho’s Medicaid VBP Program, established through [statute](#), became effective in FY2019. The program is funded through state and federal funds supplemented with a provider tax. Each facility’s contribution is adjusted based on their revenue and the federal match (FMAP) is 70%.

### Eligibility Criteria

All skilled nursing facilities are eligible to participate.

### Performance Measures

Idaho assesses performance on 10 quality measures:

- Antipsychotic medication use
- Urinary tract infections
- Pressure ulcers
- Indwelling catheter
- Decline in late-loss ADLs
- Decline in mobility
- Physical restraints
- Moderate to severe pain
- Falls with major injury
- Long stay hospitalization rate (Point Right Pro Long Stay)

### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. For each measure, the facility can earn between 20 and 100 points. If data is missing on a measure, the missing measure score is imputed based on the median quality measure score from all nursing facilities in Idaho. The program components will remain in place through FY2025 before they can be reevaluated and adjusted.

### Link to Payment

Facilities receive payment based on the aggregate score from all equally weighted measures. Once each provider’s total available fund pool is determined and their quality scores for the payment year have been tabulated, the facilities receive a percentage of their available pool based on the change from the previous year’s points. Funds remaining because of incurred penalties will be distributed amongst all participating facilities based on their Medicaid bed days.

Tier	Points	Improved by 40 Points or More	No Change	Declined by 40 Points or More
1	760-1,000	100%	100%	100%
2	680-740	100%	100%	95%
3	0-660	100%	95%	90%

## Indiana

### *Indiana Medicaid Value Based Purchasing Program*

#### **Program Establishment and Funding**

Indiana’s Medicaid VBP program became effective on July 1, 2019. The program is funded through state and federal funds supplemented with a provider tax.

#### **Eligibility Criteria**

Eligibility criteria for this program were not specified.

#### **Performance Measures**

Indiana assesses performance on 12 quality measures:

- ADL Decline
- Moderate/Severe Pain
- High Risk Pressure Ulcers
- Catheter Left in Bladder
- Urinary Tract Infection
- Physical Restraints
- Injurious Falls
- Anti-psychotic Medications
- Mobility Decline
- Nursing Home Health Survey Scores
- Nursing Facility Retention Rate
- Advance Care Planning Training Certificate

#### **Performance Assessment**

Points are assigned to each measure and performance is rated on an ordinal scale. Each measure is assigned a different number of points. Some measures use a comparison to the state average to assess performance. The program is adjusted on an as-needed basis.

#### **Link to Payment**

Facilities receive payment based on the aggregate score from all measures. Based on the number of points they receive facilities fall into one of three payment tiers. This program is relatively unique because the second payment tier uses a formula to adjust the facility’s quality add-on based on the exact number of points they received.

Tier	Points	Add-On
1	0-23	\$0.00
2	24-79	[\$18.45-((80 - Nursing Facility Total Quality Score) * 0.323684)]
3	80-100	\$18.45

## Kansas

### *Nursing Facility Quality and Efficiency Incentive Factor*

#### Program Establishment and Funding

Nursing Facility Quality and Efficiency Incentive Factor is Kansas’s first Medicaid VBP program. It was established through [statute](#) effective July 1, 2017. The program is funded through state and federal funds.

#### Eligibility Criteria

All skilled nursing facilities are eligible to participate. Eligibility is verified quarterly. In order to qualify for an incentive factor, a home must not have received any health care survey deficiency of scope and severity level “G” or higher during the survey review period. Homes 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, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level “F” will be eligible to receive 100% of the calculated incentive factor.

#### Performance Measures

The Nursing Facility Quality and Efficiency Incentive Factor program assesses performance on 3 quality measures:

- CMI adjusted staffing ratio
- Staff turnover rate and contracted labor as a percentage of total direct health care labor costs
- Medicaid occupancy

#### Performance Assessment

Performance on each measure is assessed on a pass/fail basis against specified performance thresholds. For two of the measures, the performance threshold is the 75<sup>th</sup> percentile of all facilities in the state. Facilities are not eligible for payment if data is missing on any given measure, but that does not preclude from receiving payment for the other measures. Program components are reviewed annually during the rate setting process.

#### Link to Payment

Payment to facilities is tied to individual measures. The performance thresholds and corresponding per diem incentive add-ons are as follows:

Measure Number	Quality Measures	Per Diem Incentive Add-Ons
1	CMI adjusted staffing ratio ≥ 75th percentile (5.26)	\$2.25
	CMI adjusted staffing < 75th percentile but improved ≥ 10%	\$0.20
2	Staff turnover rate ≤ 75th percentile & Contracted labor < 10% of total direct health care labor costs	\$2.25
	Staff turnover rate > 75th percentile but reduced ≥ 10% & Contracted labor < 10% of total direct health care labor costs	\$0.20
3	Medicaid occupancy ≥ 60%	\$1.00
<b>Total Incentive Add-On Available</b>		<b>\$5.50</b>

## *The Culture Change/Person-Centered Care Incentive Program*

### **Program Establishment and Funding**

The Culture Change/Person-Centered Care Incentive Program is Kansas’s second Medicaid VBP program. It was established through [statute](#) effective July 1, 2017. The program is funded through state and federal funds.

### **Eligibility Criteria**

All skilled nursing facilities are eligible to participate. Eligibility is verified quarterly. In order to qualify for an incentive factor, a home must not have received any health care survey deficiency of scope and severity level “G” or higher during the survey review period. Homes 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, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level “F” will be eligible to receive 100% of the calculated incentive factor.

### **Performance Measures**

This program is relatively unique because rather than specifying performance measures, facilities are assessed on the extent to which they have changed their culture around providing person-centered care. For example, the following is the criteria for a Level 3 facility:

*Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program.  
Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team.  
Passing a full site visit.*

### **Performance Assessment**

Facilities are assessed annually, and they are assigned to the highest level for which they meet the minimum qualifications. Program components are reviewed annually during the rate setting process.

### **Link to Payment**

The per diem incentive add-ons corresponding to each level are specified below.

<b>Level</b>	<b>Description</b>	<b>Per Diem Incentive</b>
0	The Foundation	\$0.50
1	Pursuit of Culture Change	\$0.50
2	Culture Change Achievement	\$1.00
3	Person-Centered Care Home	\$2.00
4	Sustained Person-Centered Care Home	\$3.00
5	Person- Centered Care Mentor Home	\$4.00

## ***Nursing Facility for Mental Health Quality and Efficiency Incentive Factor***

### **Program Establishment and Funding**

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor is Kansas’s third Medicaid VBP program. It was established through [statute](#) effective July 1, 2017. The program is funded through state and federal funds.

### **Eligibility Criteria**

Only skilled nursing facilities that provide mental health services are eligible to participate. Eligibility is verified quarterly. In order to qualify for an incentive factor, a home must not have received any health care survey deficiency of scope and severity level “G” or higher during the survey review period. Homes 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, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level “F” will be eligible to receive 100% of the calculated incentive factor.

### **Performance Measures**

The Nursing Facility for Mental Health Quality and Efficiency Incentive Factor assesses performance on 5 quality measures:

- CMI adjusted staffing ratio
- Total occupancy
- Operating expenses
- Staff turnover rate; proportion of total direct health care labor costs spent on contracted labor
- Staff retention

### **Performance Assessment**

Points are assigned to each measure. Some measures award points on a pass/fail basis and other award points on an ordinal basis. Facilities are not eligible for payment if data is missing on any given measure, but that does not preclude from receiving payment for the other measures. Program components are reviewed annually during the rate setting process.

### **Link to Payment**

Payment is tied to the aggregate score of all measures. Some measures are assigned more points to weight them more heavily. Payment is split into 4 tiers:

<b>Tier</b>	<b>Points</b>	<b>Per Diem Add-On</b>
1	6-8	\$7.50
2	5	\$5.00
3	4	\$2.50
4	0-3	\$0.00

## Maryland Pay for Performance

### Program Establishment and Funding

Maryland's Medicaid VBP program, established through [statute](#), became effective on January 1, 1999. The program is funded by state and federal funds, totaling 1% of the annual budget for nursing facility provider reimbursement.

### Eligibility Criteria

Skilled nursing facilities are ineligible under the following conditions: continuing care retirement communities and facilities with fewer than 45 beds; any facility identified by the CMS as a "special focus" facility; any facility which has had a denial of payment for new admissions sanction imposed by the Office of Health Care Quality (OHCQ); any facility which has been identified by OHCQ as delivering substandard quality of care. Eligibility is evaluated annually.

### Performance Measures

Maryland assesses performance on 19 quality measures:

- Staffing Levels
  - Goal 4.13 hrs (avg mix), Acuity Adjusted
  - Source-Payroll Based Journal
- Staff Stability
  - % Employed  $\geq$  2 yrs
  - MSLC Survey
- Family Satisfaction Survey
  - Overall Care Rating
  - Recommend Facility
  - Staff & Administration
  - Physical Aspects
  - Autonomy, Resident Rights
  - Care Provided
  - Food & Meals
- MDS
  - Activities
  - % High-Risk Residents w/ Pressure Sores
  - % Residents with Catheter
  - % Residents with UTI
  - % Long-Stay Residents - Flu Vaccine
  - % Long-Stay Residents - Pneumococcal Vaccine
  - % Residents with Fall/Major Injury
- Staff Immunizations
  - % of staff immunized

### Performance Assessment

Points are assigned to each measure. If the facility is missing data on any measures, they are ineligible to receive any incentives. Program components are adjusted on an as-needed basis.

### Link to Payment

Payment is tied to the aggregate score of all measures. Eighty-five percent of the program funds will be distributed to the highest-ranking facilities; it will be allocated among those facilities representing 40 percent of the eligible days of care. The Department will distribute the remaining 15 percent of the available funds to providers that are not among the highest-ranking 40 percent but have shown improvement from the prior year. No money is left over, payments are calculated as a percentage of the total budget allocated for nursing facility services.



## Massachusetts *Medicaid Quality Incentive*

### Program Establishment and Funding

Massachusetts's Medicaid [VBP program](#), established through [regulation](#), became effective October 1, 2020. The program is funded by state and federal funds, totaling \$95 million in Rate Year 2021.

### Eligibility Criteria

The eligibility criteria for this program were not specified.

### Performance Measures

Massachusetts's assesses performance on 4 quality measures:

- Quality Achievement Based on CMS overall Five Star rating
- Quality Improvement Based on change in CMS overall Five Star rating
- Quality Achievement Based on DPHs Nursing Facility Survey Performance Tool (DPH NFSPT) survey inspection Score
- Quality Improvement Based on change in DPH DPHs Nursing Facility Survey Performance Tool (DPH NFSPT survey inspection Score)

### Performance Assessment

For each of the 4 performance measures, the percentage adjustment to the nursing facility's per diem rate is specified for multiple performance thresholds within the measure. The program components are reviewed annually.

### Link to Payment

The quality adjustment is equal to the sum of the percent increase or decrease assessed for performance on each of the four quality measures. Payment adjustments are made based on performance in each of the 4 domains. The aggregate quality adjustments can range from -8% to 6%.

## Michigan

### *Nursing Facility Quality Measure Initiative*

#### **Program Establishment and Funding**

Michigan's Medicaid VBP program, established through [regulation](#), became effective October 1, 2017. The program is funded by state and federal funds supplemented with a provider tax, with a cap of \$73 million on the funds derived from the provider tax.

#### **Eligibility Criteria**

Skilled nursing facilities are eligible under the following conditions: the provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period; the provider must be a Class I or III nursing facility; the provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC website; the provider must be a Medicaid-certified nursing facility; the provider must not be closed for business; the provider must not be designated as a Special Focus Facility (SFF) by CMS; and if the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Long Term Care Policy Section as described in this section.

#### **Performance Measures**

Michigan assesses performance on 4 quality measures:

- Average 5-star quality measure rating on the CMS NHC website
- Medicaid utilization rate
- Number of licensed beds
- Resident satisfaction survey data

#### **Performance Assessment**

The raw data is recorded for each measure. For example, the number of licensed beds is recorded as an integer and the Medicaid utilization rate is recorded as a percentage. Unlike most other programs, specified performance thresholds and corresponding assignment of points are not relevant in this performance assessment system.

#### **Link to Payment**

Payment is tied to the aggregate of all measures using the following formula. The yearly QMI payment is distributed as a monthly gross adjustment.

$$\text{QMI Gross Adjustment} = \left( \left( [\text{NHC Per-Bed Amount}] * [\text{Medicaid Utilization Scale}] * [\text{Resident Satisfaction Survey Factor}] \right) * [\text{Number of Licensed Nursing Facility Beds}] \right) / [\text{Number of Eligible Payment Months}]$$

## Minnesota

### *Quality Improvement Incentive Program (QIIP)*

#### **Program Establishment and Funding**

Quality Improvement Incentive Program is Minnesota's first Medicaid VBP program. The program was established through [statute](#), effective January 1, 2014. Funded by state and federal funds, the annual pool available for quality improvement incentive payments shall be equal to 0.8% of all operating payments.

#### **Eligibility Criteria**

All Medicaid-certified skilled nursing facilities are eligible to participate.

#### **Performance Measures**

Facilities select one measure from a pre-approved list and receive payment based on improvement on that measure.

#### **Performance Assessment**

The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The Department of Human Services (DHS) creates a report for each nursing facility that summarizes the facility's performance on each measure and displays the performance improvement needed. A facility has two possible ways to improve a measure:

- Goal using Standard Deviation: DHS uses this approach if a facility's baseline score on a given quality topic is like most other facilities in the state. Facilities meet this goal when they improve their quality measure score by one standard deviation.
- Goal using Percentiles: DHS uses this approach if a facility's baseline score on a quality topic is among the lowest performing 25% of providers for a given measure. Facilities meet this goal when they bring their score down to the 75<sup>th</sup> statewide percentile value (or bring it up to the 25<sup>th</sup> statewide percentile value for measures where a higher score is better).

#### **Link to Payment**

Facilities will receive a per diem increase between \$0.00 and \$3.50.

## *Value Based Reimbursement (VBR)*

### **Program Establishment and Funding**

Value Based Reimbursement is Minnesota's second Medicaid VBP program. The program was established through [statute](#), effective January 1, 2016. It is funded by state and federal funds.

### **Eligibility Criteria**

All Medicaid-certified skilled nursing facilities are eligible to participate. The program is voluntary, although participation is nearly universal.

### **Performance Measures**

The Value Based Reimbursement program assesses performance on 8 quality measures:

- Long stay
  - Quality of Life In-Person Resident Survey Results
  - Family Satisfaction Mailed Survey Results
  - Long-Stay Quality Indicator Score
- Short stay
  - Resident Experience Mailed Survey Results
  - Rate of Hospitalizations within 30 Days
  - Score on Moderate to Severe Pain Short-Stay Quality Indicator
  - Score on New or Worsening Pressure Sores Short-Stay Quality Indicator
- All residents
  - MDH Inspection Results

### **Performance Assessment**

Points are assigned to each measure and performance is rated on an ordinal scale. Data is imputed from the state average score when facilities are missing data on any given measure. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner. Changes are effective on July 1 of every year and must be preceded by 5 months of advance public notice.

### **Link to Payment**

Facilities receive payment based on the aggregate score of all performance measures. Points are assigned to each measure to weight some more heavily than others; long-stay and short-stay scores are also weighted to reflect the distribution of residents in each facility. Facility's quality score is entered into a formula to determine payment, as outlined in the statute.

## Nebraska *Nursing Home Payment Project*

### Program Establishment and Funding

Nebraska's Medicaid VBP program, established through [statute](#), became effective July 1, 2021. Funded by state and federal funds, it is projected that this program will use 2.9% of the available nursing facility budget in the state.

### Eligibility Criteria

This program uses the 5-star system to establish eligibility. Skilled nursing facilities must be stars or above to participate.

### Performance Measures

Each facility's performance is assessed using the "Quality Measures" Component of the CMS Nursing Facility Star Rating system.

### Performance Assessment

Facilities are assessed using the "Quality Measures" Component of the CMS Nursing Facility Star Rating system, which assigns one score based on 15 quality measures.

### Link to Payment

The following per diem add-ons is assigned to each star rating:

CMS Star Rating	Per Diem Add-On
5	\$10.00/day
4	\$6.75/day
3	\$3.50/day
2	No add-on
1	No add-on
No Rating	No add-on

## New Jersey

### *New Jersey Quality Incentive Payment Program*

#### **Program Establishment and Funding**

New Jersey's Medicaid VBP program, established through [statute](#), became effective July 1, 2019. The program is funded by state and federal funds supplemented with a provider tax. The total allocation for quality funding distribution for FY2022 is \$20 million.

#### **Eligibility Criteria**

All Medicaid skilled nursing providers may participate in the program if they utilize a Hospital (Rehospitalization) Utilization tool and at least be vetted for the Core Q Resident Satisfaction Survey.

#### **Performance Measures**

New Jersey assesses performance on 6 quality measures:

- % of long stay residents who are physically restrained at or below the state average
- % of long stay residents receiving antipsychotic medication at or below the state average
- % of long stay residents experiencing one or more falls with major injury at or below the state average
- % of long stay, high risk residents with a pressure ulcer at or below the state average
- % of long stay residents who are given, appropriately, the influenza vaccination during the most recent influenza season at or above the state average
- The long stay resident/family CoreQ Composite score at or above the established benchmark

#### **Performance Assessment**

Each measure is assessed on a pass/fail basis. The performance threshold for 5 of the 6 measures is the state average. If a facility is missing data on any of the measures, they will not be eligible for payment on those measures. Program components are evaluated and adjusted annually.

#### **Link to Payment**

Payment is tied performance on each individual measure. Facilities that perform at or better than the performance threshold received an additional \$0.60 per measure in FY2020 and FY2021.



## New Mexico

### Health Care Quality Surcharge Payment Program

#### Program Establishment and Funding

Health Care Quality Surcharge Payment Program is New Mexico’s first Medicaid VBP program. The program was established through [statute](#), effective January 1, 2020. It is funded by state and federal funds supplemented with a provider tax. Between July 2019 and June 2020, \$81.1 million was paid to providers.

#### Eligibility Criteria

The surcharge is imposed on each facility that meets the definition of a skilled nursing facility, intermediate care facility, or intermediate care facility for individuals with intellectual disabilities. A skilled nursing facility is a facility with greater than sixty beds and is licensed by the Department of Health to provide skilled nursing services. An intermediate care facility is a facility with greater than sixty beds and is licensed by the Department of Health to provide intermediate nursing care. An intermediate care facility for individuals with intellectual disabilities is a facility licensed by the Department of Health to provide food, shelter, health or rehabilitative and active treatment for individuals with intellectual disabilities or persons with related conditions.

#### Performance Measures

The Health Care Quality Surcharge Payment Program assesses performance on 4 quality measures:

- Falls with Major Injury
- Depression
- Flu Shot
- Pneumonia Vaccine

#### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. Each of the measures are worth 100 points, for a maximum total of 400 points. When data is missing on a measure, the facility is assumed to perform at the state average. The quality measures and performance thresholds may not be changed during the first two years of the program.

#### Link to Payment

Facilities receive payment based on the aggregate score of 4 equally weighted measures. First, a per diem rate for each Quarter will first be established by dividing the total number of dollars available in the Total Funds by the total number of Medicaid Bed Days across all facilities and MCOs. Then, facilities are assigned to tiers based on their aggregate quality measure score. The applicable tier percentage is then applied to the per diem rate, and the resulting rate multiplied by the number of Medicaid Bed Days attributable to the applicable Facility during the applicable Quarter, to determine the Initial Quality Performance Amount for that Facility. In first year of the program, all tiers will receive 100% of their per diem rate. In the second year, each tier will receive a different percentage of their per diem rate. The tier percentages for the third and fourth year have not yet been determined.

Tier	Points	Year 1 Percentage of Per Diem Rate	Year 2 Percentage of Per Diem Rate
1	320 points or more	100%	100%
2	319 to 260 points	100%	95%
3	259 to 200 points	100%	90%
4	199 to 140 points	100%	85%
5	139 points or less	100%	75%

## Nursing Facility Value Based Payment Program

### Program Establishment and Funding

Nursing Facility Value Based Payment Program is New Mexico’s second Medicaid VBP program. The program became effective on January 1, 2020 and is funded by state and federal funds. \$5 million are budgeted annually for this program.

### Eligibility Criteria

To be eligible for the Nursing Facility VBP Program, the facility must: be a Medicaid Certified facility; contract with at least 1 Medicaid MCO; submit Minimum Data Set (MDS) data to the Data Vendor; have Medicaid utilization during the measurement quarter; and have data use agreements signed with Data Vendor and MCOs.

### Performance Measures

The Nursing Facility Value Based Payment Program assesses performance on 4 quality measures:

- Long-stay Antipsychotic
- UTI
- PointRight LS Hospitalization
- Long-stay High Risk Pressure Ulcer

### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. Each of the measures are worth 100 points, for a maximum total of 400 points. When data is missing on a measure, the facility is assumed to perform at the state average. The quality measures and performance thresholds may not be changed during the first two years of the program.

### Link to Payment

Facilities receive payment based on the aggregate score of 4 equally weighted measures. A per diem rate will be established by dividing the (VBP pool – foundational payments for infrastructure and operations – secondary payment) / total Medicaid bed days for participating facilities. Each facility is eligible to receive the full per diem rate per their Medicaid Bed Days. Payment calculation shall be: (facility Medicaid bed days) x (per diem rate) x (tier percentage). A tier percentage would be applied to the per diem rate. The tier percentage is based on the performance tier a facility achieves based on their quality measures. The associated percentage will be multiplied by the per diem rate. Facilities are assigned to tiers based on their aggregate quality measure score.

	Tier 1 (260 points or more)	Tier 2 (200-259 points)	Tier 3 (140-199 points)	Tier 4 (100-139 points)	Tier 5 (99 points or less)
1st year	100%	85%	75%	50%	20%
2nd year	100%	85%	75%	50%	10%
3rd year	100%	85%	75%	50%	0%
4th year	100%	85%	75%	50%	0%
5th year	100%	85%	75%	50%	0%

## New York NYS Medicaid Value Based Payment

### Program Details

New York's Medicaid VBP Program, established through [regulation](#), became effective on January 1, 2017. New York's program is relatively unique because the state will provide guidance but will not dictate any of the terms of value-based arrangements between MCOs and their providers.

### Performance Measures

New York recommends 36 performance measures, each of which apply to Programs of All-Inclusive Care for the Elderly (PACE) and/or Medicaid Advantage Plus (MAP) organizations.

#### **PACE**

- % of participants with an advance directive or surrogate decision maker documented in the medical record and percentage with annual review
- % of participants not in nursing homes
- ED use without hospitalization

#### **MAP**

- Comprehensive diabetes care: eye exam
- Colorectal cancer screening
- Antidepressant medication management
- Follow up after hospitalization for mental illness
- Initiation and engagement of alcohol and other drug dependence treatment

#### **PACE & MAP**

- % of members without an emergency room visit in the last 90 days (considered as 2 measures from different data sources)
- % of members without a fall that resulted in major or minor injury in the last 90 days
- % of members who received an influenza vaccination in the last year
- % of members who were stable/improved in pain intensity
- % of members who were stable/improved in NFLOC score
- % of members who were stable/improved in urinary continence
- % of members who were stable/improved in shortness of breath
- % of members without uncontrolled pain
- % of members not lonely/distressed
- Potentially avoidable hospitalizations for a primary diagnosis of heart failure,

respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection (considered as 2 measures from different data sources)

- % of long stay (LS) high risk residents with pressure ulcers
- % of LS residents who received the pneumococcal vaccine
- % of LS residents who received the seasonal influenza vaccine
- % of LS residents experiencing one or more falls with major injury
- % of LS residents who lose too much weight
- % of LS residents with urinary tract infection
- Care for older adults - medication review
- Use of high-risk medications in the elderly
- % of LS low risk residents who lose control of their bowel or bladder
- % of LS residents whose need for help with daily activities has increased
- % of members who rated the quality of home health/personal care aide services within the last 6 months as good/excellent
- % of members who responded that they were usually or always involved in making decisions about their plan of care
- % of members who reported that home health/personal care aide services were always/usually on time in the last 6 months
- % of LS residents with depressive symptoms
- % of LS residents with dementia who received an antipsychotic medication
- % of LS residents who self-report moderate to severe pain

## Ohio

### *Nursing Facility's per Medicaid Day Quality Incentive Payment Rate*

#### **Program Establishment and Funding**

Ohio's Medicaid VBP program, established through [statute](#), became effective June 19, 2020. The program is funded by state and federal funds.

#### **Eligibility Criteria**

Skilled nursing facilities are ineligible if their licensed occupancy percentage is less than 80%, with possible exceptions outlined in the statute.

#### **Performance Measures**

Ohio assesses performance on 4 quality measures:

- % of the long-stay residents at high risk for pressure ulcers who had pressure ulcers
- % of the long-stay residents who had a urinary tract infection
- % of the long-stay residents whose ability to move independently worsened
- % of the long-stay residents who had a catheter inserted and left in their bladder

#### **Performance Assessment**

Points are assigned to each measure and performance is rated on an ordinal scale. A nursing facility's quality score for state fiscal year 2021 shall be the sum of the total number of points that CMS assigned to the nursing facility under CMS's nursing facility five-star quality rating system for the most recent four-quarter average data available in the database maintained by CMS' Nursing Home Compare. In determining a nursing facility's quality score for state fiscal year 2021, the department shall divide the number of the nursing facility's points for each quality metric by twenty. If CMS assigned the nursing facility to the lowest percentile for the quality metric, the facility's points for the quality metric will be reduced to zero.

#### **Link to Payment**

Facilities receive payment based on the aggregate score of all measures. For state fiscal year 2021, the Department of Medicaid will determine each nursing facility's per Medicaid day quality incentive payment rate by first determining the sum of the quality scores determined for all nursing facilities. Then, they determine the average quality score by dividing the sum or the quality scores by the number of nursing facilities for which a quality score was determined. Next, they determine the sum of the total number of Medicaid days for all of calendar year 2019 for all nursing facilities for which a quality score was determined. They multiply the average quality score by the total number of Medicaid days. Next, they determine the value per quality point. Finally, payment is calculated by multiplying the value per quality point by the nursing facility's quality score.

## Oklahoma

### *Pay for Performance in Long Term Care*

#### **Program Establishment and Funding**

Oklahoma's Medicaid VBP program, established through [statute](#), became effective October 1, 2019. The program is funded by state and federal funds supplemented with a provider tax, with an average annual budget of \$13.5 million.

#### **Eligibility Criteria**

All Medicaid-participating skilled nursing facilities are eligible, provided they submit data via the State Medicaid Pay for Performance portal.

#### **Performance Measures**

Oklahoma assesses performance on 4 quality measures:

- Percentage of long-stay residents who lose too much weight
- Percentage of long-stay residents with high risk/unstageable pressure ulcers
- Percentage of long-stay residents with a urinary tract infection
- Percentage of long-stay residents who received an antipsychotic

#### **Performance Assessment**

Each measure is assessed on a pass/fail basis. Each quarter, a facility's 5% relative improvement target increases. If the facility does not meet the 5% relative improvement target each quarter or meet/exceed the national average, the facility will not receive payment. Missing data on a measure disqualifies the facility from earning the payment for that measure. The facility can still receive payment for other measures. The national benchmarks used as performance thresholds are updated annually.

#### **Link to Payment**

Payment is tied to performance on individual measures. Each measure is worth \$1.25 per Medicaid beneficiary per day. Payments are distributed quarterly.

## Tennessee Nursing Facility Provider Reimbursement

### Program Establishment and Funding

Tennessee's Medicaid VBP program, established through [statute](#), became effective July 1, 2018. The program is funded by state and federal funds.

### Eligibility Criteria

Skilled nursing facilities are eligible to participate if they follow the methodology set forth by TennCare and NRC Health for each surveying the satisfaction of residents, family members, and staff.

### Performance Measures

Tennessee assesses performance on 14 quality measures:

- Resident satisfaction
- Family satisfaction
- Staff satisfaction
- Respectful treatment
- Resident choice
- Resident and family input
- Meaningful activities
- Registered Nurse (RN) hours per resident day
- Nurse Aide (NA) hours per resident day
- RN, LPN, and CNA staff retention
- Consistent Staff Assignment
- Staff training (onboarding and continuing)
- Percentage of long-stay residents who receive an antipsychotic medication
- Percentage of short-stay residents who receive an antipsychotic medication

### Performance Assessment

Points are assigned to each measure and performance is rated on an ordinal scale. Program components can be adjusted on rebasing years, which occur every 3 years.

### Link to Payment

Facilities receive payment based on the aggregate performance on all measures. Measures are assigned a varying number of points to weight some more heavily than others. There are three payment tiers. The cut points for each tier were specified, but not the corresponding payment.

Quality Tier	Cut Point Range
1	75-100
2	50-74.99
3	0-49.99



## Texas

### *Quality Incentive Payment Program (QIIP)*

#### **Program Establishment and Funding**

Texas's Medicaid VBP program, established through [statute](#), became effective on September 1, 2017. The program is funded by state and federal funds. The budget varies by year, totaling \$399 million in the first year, \$446 million in the second year, and \$600 million in the third year.

#### **Eligibility Criteria**

All privately owned nursing facilities are eligible; government-owned facilities are excluded from certain components of the program.

#### **Performance Measures**

Texas assesses performance on 4 quality measures:

- Quality Assurance and Performance Improvement (QAPI) Meetings
- RN staffing hours per day, relative to the CMS mandate
- NF has a workforce development program in the form of a PIP
- % of high-risk residents with pressure ulcers, including unstageable pressure ulcers
- % of residents who received an antipsychotic medication
- % of residents whose ability to move independently has worsened
- % of residents with a urinary tract infection
- Facility has active infection control program
- Quarter-specific infection control performance targets:
  - Quarters 1 & 3: submit evidence-based infection control policies and supporting documentation
  - Quarter 2 Performance Target:
    - Administrator and Director of Nursing submit current certificate of completion for CMS and CDC's "Nursing Home Infection Preventionist Training Course"
    - Infection control policies demonstrating data-driven analysis of performance and evidence-based methodologies for intervention
  - Quarter 4 Performance Targets:
    - % of residents assessed and appropriately given the pneumococcal vaccine
    - % of residents assessed and appropriately given the influenza vaccine

#### **Performance Assessment**

Each measure is scored on a pass/fail basis. Performance thresholds are derived either from the state average or CMS' Minimum Data Set. Every 2 years, a stakeholder reevaluates the program components.

#### **Link to Payment**

Payment is tied to individual measures on a pass/fail basis. The size of the payment for each measure was not specified.

## Utah

### *Quality Improvement Incentive 1*

#### **Program Establishment and Funding**

Quality Improvement Incentive Program 1 is Utah's first Medicaid VBP program. The program is funded by state and federal funds, with a total budget of \$1 million. The size of the budget remains the same every year.

#### **Eligibility Criteria**

All facilities are eligible if they complete the application and provide all supporting documents.

#### **Performance Measures**

The Quality Incentive Improvement (QII 1) Program 1 assesses performance on 3 quality measures:

- This Facility has created and implemented a meaningful Quality Improvement plan which includes the involvement of residents and family.
  - This facility has a demonstrated process by which its Quality Improvement plan is assessed and measured.
  - This facility had customer satisfaction surveys conducted by an independent third-party entity in each quarter of the incentive period.
- This facility embraces and has implemented a Culture Change.
- This facility has implemented an employee satisfaction program.

#### **Performance Assessment**

A weighted percentage is assigned to each measure. A facility with missing data is ineligible for payment. Program components can be adjusted annually, if needed.

#### **Link to Payment**

Payment is tied to the aggregate of the performance measures. The size of the payment was not specified. Any remaining funds in the budget not paid out in QII1 and QII2 are available for payout to qualifying facilities in QII3.

## *Quality Improvement Incentive 2*

### **Program Establishment and Funding**

Quality Improvement Incentive Program 2 is Utah's second Medicaid VBP program. The program is funded by state and federal funds, with a total budget of \$4.3 million. The size of the budget remains the same every year.

### **Eligibility Criteria**

All facilities are eligible if they complete the application and provide all supporting documents.

### **Performance Measures**

The Quality Incentive Improvement (QII2) Program 2 assesses performance on 12 quality measures:

- Purchased a new nurse call system or enhancements to its existing system
- Purchased one or more new patient lifts (up to 400-pound capacity)
- Purchased one or more patient bathing improvements
- Purchased or enhanced one or more patient life-enhancing devices
- Educated its staff
- Purchased or made improvements to vans and van equipment for patient use
- Purchased or leased new or enhanced existing clinical information systems software
- Purchased a new or enhanced its existing HVAC system
- Used innovative means to improve the residents' dining experience
- Obtained an outcome-proven award (American Health Care Association Quality-First Award or the Malcolm Baldrige award)
- Provided flu or pneumonia immunizations for its workers free of charge
- Purchased new patient dignity devices

### **Performance Assessment**

Performance thresholds are specified for each measure. A facility with missing data is ineligible for payment. Program components can be adjusted annually, if needed.

### **Link to Payment**

Incentive payments are tied to each measure. The maximum a facility may receive from all incentives combined is \$598.45 per Medicaid Certified bed (as of 7/1/2020). Facilities will not receive more than was expended to meet the requirement under this incentive. Any remaining funds in the budget not paid out in QII1 and QII2 are available for payout to qualifying facilities in QII3.

## *Quality Improvement Incentive 3*

### **Program Establishment and Funding**

Quality Improvement Incentive Program 3 is Utah's third Medicaid VBP program. This program's budget is based on funds leftover from the other two Quality Improvement Incentive programs.

### **Eligibility Criteria**

All facilities are eligible if they complete the application and provide all supporting documents.

### **Performance Measures**

The Quality Incentive Improvement (QII3) Program 3 assesses performance on 3 quality measures:

- Awake time
- Mealtime
- Bath time

### **Performance Assessment**

The performance assessment methodology was not specified. A facility with missing data is ineligible for payment. Program components can be adjusted annually, if needed.

### **Link to Payment**

Funds leftover from QII1 and QII2 are available for QII3. Beyond that, the payment methodology for this program was not specified.

## Washington

### *Skilled Nursing Facility Medicaid Reimbursement System*

#### **Program Establishment and Funding**

Washington's Medicaid VBP program, established through [statute](#), became effective July 1, 2016. The program is funded by state and federal funds, totaling \$8.3 million.

#### **Eligibility Criteria**

All skilled nursing facilities are eligible to participate.

#### **Performance Measures**

Washington assesses performance on 4 quality measures:

- % residents with a urinary tract infection
- % high-risk residents with pressure ulcers
- % residents experiencing one or more falls with major injury
- % residents who self-report moderate to severe pain

#### **Performance Assessment**

Points are assigned to each measure and performance is rated on an ordinal scale.

Performance thresholds are not based on the state average. If data is missing, the facility's 5-stay rating is used to assign them to a payment tier. A workgroup conducts an annual evaluation of the program components.

#### **Link to Payment**

Payment is tied to the aggregate of the 4 equally weighted measures. Based on the facility's score out of 100 points, they are assigned to one of 5 payment tiers. The size of payment is adjusted based on how many facilities fall into each tier, so there is never unused money.

Tier	Points	Per Diem Add-On
5	80-100	\$7.72
4	70-79	75% of tier 5 incentive
3	60-69	50% of tier 5 incentive
2	50-59	25% of tier 5 incentive
1	0-49	No payment