STATUS REPORT TO THE LEGISLATURE

Quality and Accountability Supplemental Payment Program

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Department of Health Care Services

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I. OVERVIEW

Senate Bill (SB) 853 (Chapter 717, Statutes of 2010) established the Quality and Accountability Supplemental Payment (QASP) Program to encourage and incentivize skilled nursing facilities (SNFs), as defined in Health and Safety Code Section 1250(c), to implement quality improvements by awarding supplemental payments to eligible facilities. The SNF Quality and Accountability Special Fund, established by SB 853, contains moneys from the assessment of specified administrative penalties and set asides of General Fund (GF) moneys, for the purposes of making quality and accountability supplemental payments. The supplemental payments are funded by capping the Medi-Cal reimbursement for professional liability insurance at the 75th percentile and diverting the savings to the Special Fund. Assembly Bill (AB) 119 (Chapter 17, Statutes of 2015) extended the QASP Program through July 31, 2020. The bill also replaced the set aside with an annual GF appropriation beginning in fiscal year (FY) 2015-16. Additionally, AB 119 required the Department of Health Care Services (DHCS) to incorporate direct care staff retention as one of the performance measures for the QASP Program beginning in FY 2015-16.

In consultation with various stakeholder groups, DHCS and the Department of Public Health (CDPH) worked together to develop the QASP Program methodology for the distribution and allocation of supplemental payments. Stakeholders included long-term care industry representatives, labor representatives, consumers and consumer advocates. Prior to implementation, DHCS and CDPH analyzed program options, reviewed existing similar programs, identified elements of a framework for the program, and developed payment methodologies. Stakeholder feedback was incorporated throughout the development of the QASP Program through regularly held meetings and conference calls. The QASP Program payment methodology includes a tiered system for program eligibility and the distribution of supplemental payments. Two (2) types of supplemental payments are available for SNFs, referred to as Incentive and Improvement Payments (described below). The QASP Program was phased in during FY 2010-11, in compliance with W&I Code 14126.022(a)(3).

Pursuant to California's State Plan, as approved by the Centers for Medicare and Medicaid Services (CMS), only SNFs with at least one (1) Fee-For-Service (FFS) Medi-Cal Bed Day (MCBD) are eligible to participate in the QASP Program. The total MCBDs are derived from facility-reported data to the Office of Statewide Health Planning and Development (OSHPD) which is audited by the DHCS Audits and Investigations program.

Consistent with W&I Code 14126.022(a), the program was implemented on August 1, 2011. Data collected from August 2011 through July 2012 was used for the purpose of establishing a baseline for determining future improvement in each SNFs performance. The first performance period was FY 2012-13, with Incentive and Improvement Payments issued in FY 2013-14. The second performance period was FY 2013-14 with Incentive and Improvement Payments issued in FY 2014-15.

In accordance with W&I Code 14126.022(a)(4), the QASP Program assesses overall SNF quality, assigns payments, publishes each eligible facility's Improvement and/or Incentive Payments, and publishes direct-care staffing level data and performance measures. The information is located on the DHCS and the CDPH websites.

II. METHODOLOGY DESCRIPTION: TIER SYSTEM

As noted above, in consultation with various stakeholder groups, DHCS and CDPH developed a tier system to facilitate QASP Program eligibility and distribution of funds. The purpose of the tiered system is to measure and promote increased quality performance and reward only those SNFs that maintain and/or improve quality care over time. Facilities that are not meeting minimum standards, and in some cases had performance issues, are not rewarded.

The tier system uses quality measures obtained from the Minimum Data Set (MDS) data file provided quarterly by CMS and, more recently, has added a staff retention measure based on the same facility cost reports used to establish the MCBDs. The MDS file contains quarterly resident assessments and self-reported data from SNFs. CMS ensures that the MDS data set has been assessed, validated, endorsed, and is appropriate for use. The independent National Quality Forum (NQF) also validates and endorses the use of MDS to assess and measure nursing home quality.

In consultation with various stakeholder groups, DHCS and CDPH developed criteria to select which quality measures to use in the tiered system formula. Selection criteria for quality measures included scientific acceptability, feasibility and usability compared to related and competing measures. Each selected quality measurement area was assigned an equal value. Some areas had multiple quality measures and, in these cases, points are allocated equally within each area across the measures. Annual data submitted by SNFs is evaluated, tabulated and scored, and each SNF is given an overall 'quality of care' score that translates to their tier placement. Facilities that meet the statewide average benchmark receive half the points allocated for each quality measure, while those meeting or exceeding the seventy-fifth (75th) percentile, receive a full-point allocation.

The CDPH Center for Health Care Quality contracts with the Health Services Advisory Group (HSAG) to score and rank, by tier, each SNF using the QASP Program Quality Measures Scoring System (shown in chart below). The scores and tier ranking are tabulated by HSAG, reviewed and approved by CDPH, and then submitted to DHCS for distribution of the QASP Program funds.

The tier system places all SNFs in one of four (4) tiers:

- Tier 0 facilities are not eligible for the QASP Program;
- Tier 1 facilities are not eligible for Incentive Payments, but are eligible for Improvement Payments;
- Tier 2 facilities are eligible for both Incentive and Improvement Payments;

- Tier 3 facilities are eligible for both Incentive and Improvement Payments at an enhanced amount (1.5 times higher than tier 2).

HSAG assigns a SNF to Tier 0 when one of the following occurs:

1) The SNF fails to submit quality measure data as requested by DHCS for the MDS quality measures.

2) The SNF does not have at least one MCBD.

3) The SNF does not meet the 3.2 Nursing Hours Per Patient Day (NHPPD) requirement monitored by the CDPH Staffing Audits Section (SAS). The CDPH SAS audits approximately 1,200 SNFs annually and determines compliance with the 3.2 NHPPD staffing requirement through a review of payroll records, assignment sheets, and other documentation.

4) The SNF receives a class A or AA citation during the performance period. CDPH District Offices issue various citations based on the severity of adverse resident events. Class "A" citations are issued when CDPH determines that the violation presents an imminent danger or a substantial probability of harm to patients. Class "AA" citations are issued when CDPH determines that the violation has a direct proximate cause of death.

The FY 2011-12 baseline year was established for the QASP Program and data for three (3) quality measurement areas was collected. These same quality measurement areas: Pressure Ulcers, Physical Restraints, and Immunizations were used for the first performance period (FY 2012-13). Three (3) additional quality measurement areas were added in FY 2013-14: Urinary Tract Infections, Control of Bowel/Bladder, and Self-Reported Moderate to Severe Pain. Additional quality measures were added as new areas, including Activities of Daily Living (ADL) in FY 2014-15 and staff retention in FY 2015-16.

Figure 1: Depicts the quality measurement areas and maximum score value for each measure.

QASP PROGRAM QUALITY MEASURES SCORING SYSTEM					
Performance Period	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Payment Period (Rate Year)	**Baseline***	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Measurement Area 2011-12 & 2012-13					
Pressure Ulcers	33.34	33.34	16.67	14.29	12.50
Physical Restraints	33.34	33.34	16.67	14.29	12.50
Immunizations	33.32	33.32	16.67	14.29	12.50
Added FY 2013-14					
Urinary Tract infection	-	-	16.67	14.29	12.50
Control Of Bowel/Bladder	-	-	16.67	14.29	12.50
Self-Report Moderate to Severe Pain	-	-	16.67	14.29	12.50

Added FY 2014-15					
Activities of Daily Living	-	-	-	14.29	12.50
Added FY 2015-16					
Staff Retention	-	-	-	-	12.50
TOTAL POINTS	**100**	**100**	**100**	**100**	**100**

*Baseline data was collected in the first year. Scoring results in the subsequent years were compared for each SNF for awarding Improvement Payments.

Figure 2: Depicts the QASP Program tiers and the Quality Measures Score thresholds.

Tier	Quality Measure Score
0	Ineligible
1	< 50.00 points
2	> = 50.00 and < 66.67
3	> = 66.67

Figure 3: Illustrates the QASP Program tiered distribution for SNFs in the baseline year and the first two performance periods; FY 2012-13, FY 2013-14.

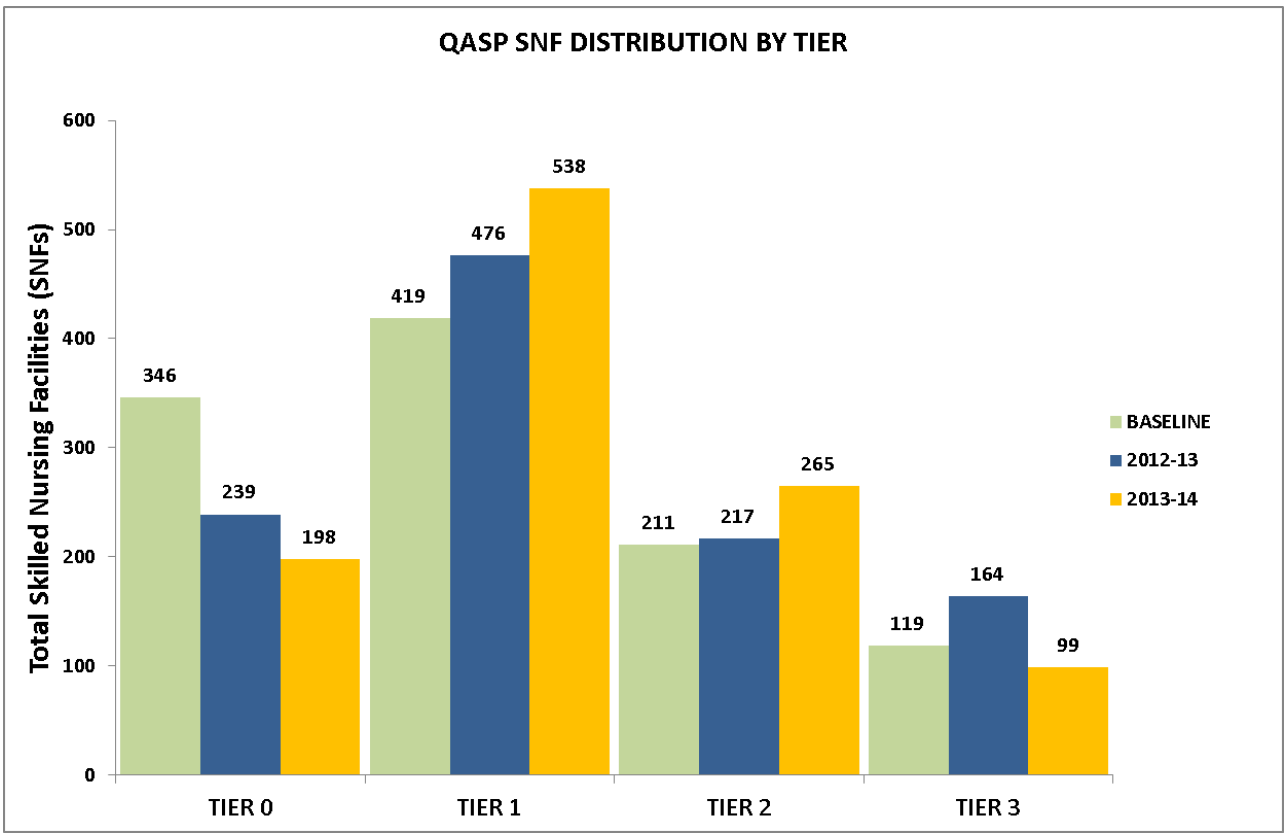


Figure 4: Depicts the QASP Program tiered distribution for SNFs in the baseline year and the first two performance periods; FY 2012-13, FY 2013-14.

SNF TIER DISTRIBUTION FOR QASP PROGRAMS				
Payment Period (Rate Year)		**2013-14**	**2014-15**	
TIER	**BASELINE**	**Performance Period 2012-13**	**Performance Period 2013-14**	**PERCENT CHANGE BETWEEN 2012-13 & 2013-14**
0	346	239	198	-17%
1	419	476	538	13%
2	211	217	265	22%
3	119	164	99	-40%
TOTAL	**1095**	**1096**	**1100**	**0%**

The QASP Program was designed to provide Incentive Payments to SNFs based on eligibility standards and quality measures. SNFs that meet eligibility standards are able to earn larger Incentive Payments by achieving higher scores in their quality measures. SNFs can also earn additional Improvement Payments by ranking in the top 20th percentile for improvement scores between the performance period and the previous year.

III. INCENTIVE PAYMENTS

DHCS and CDPH developed the allocation methodology for QASP Program Incentive Payments to incentivize lower performing SNFs to improve their overall facility quality and to award high performing SNFs that maintain their overall facility quality. The awards to SNFs are based on a tiered ranking and the number of MCBDs provided by the facility. The tier system incentivizes SNFs to improve quality of care by increasing its quality measures score, and thus its ranking, from year to year. The threshold for payout per MCBD is based on whether a SNF meets and/or exceeds the points within a payment tier.

Figure 5: Allocation of the QASP Program Incentive Payments by tier is as follows:

Tier	Points	Eligibility	Payment
0	N/A	Ineligible	None
1	<50	Ineligible	None
2	> or =50	Eligible	100%
3	>=66.67	Eligible	150%

SNFs in Tier 3 are incentivized to maintain a high level of quality to continue to receive the enhanced Incentive Payment.

Figure 6: Total number of qualifying SNFs with the percentage that received QASP Program Incentive Payments; Rate Years 2013-14 and 2014-15.

QASP INCENTIVE PAYMENTS (TIER 2 SNFs + TIER 3 SNFs)				
Payment Period (Rate Year)		**2013-14**	**2014-15**	
TOTAL	**BASELINE**	**Performance Period 2012-13**	**Performance Period 2013-14**	**PERCENT CHANGE BETWEEN 2013-14 AND FY 2014-15**
SNFs	330	381	364	-17
Percent	30%	35%	33%	-2%

Figure 7: Total QASP Program Incentive Payments by tier; Rate-Years 2013-14, FY 2014-15.

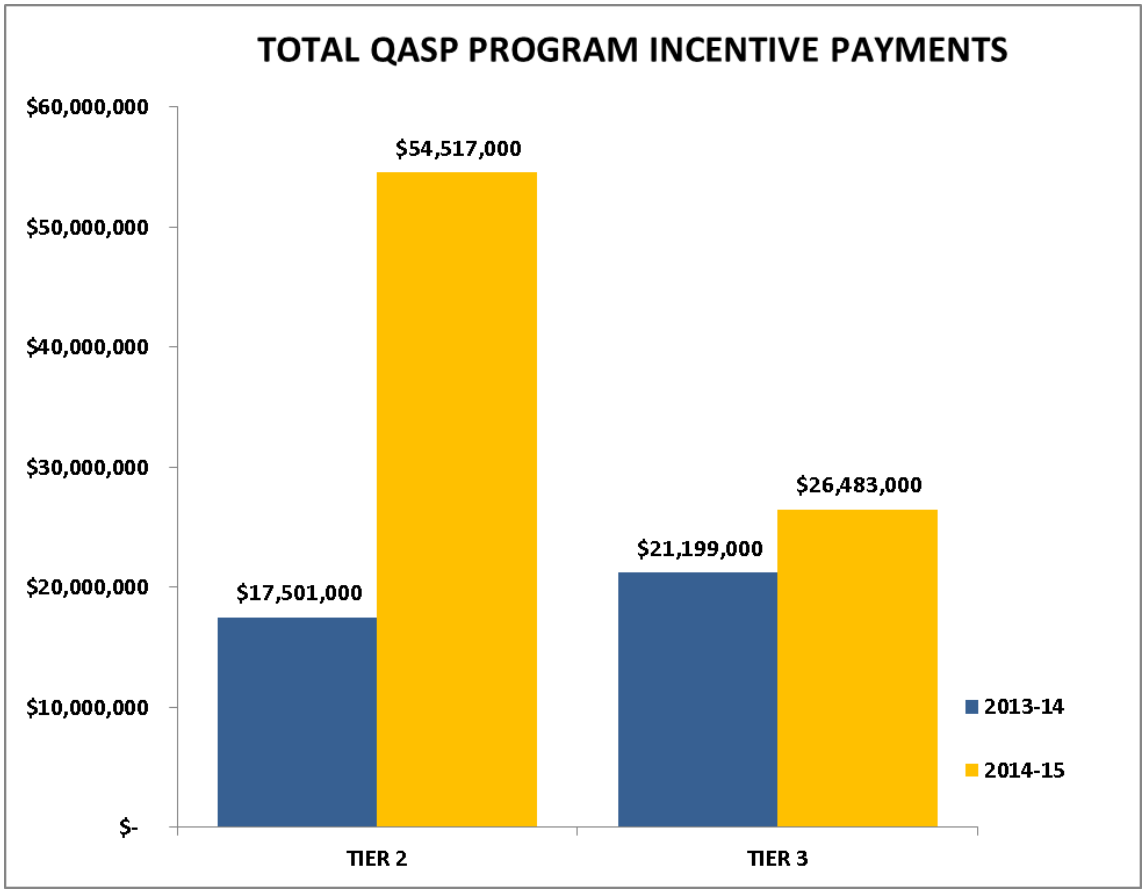


Figure 8: Difference between Rate Years 2013-14 and 2014-15 in QASP Program Incentive Payments.

TOTAL QASP PROGRAM INCENTIVE PAYMENTS			
Payment Period (Rate Year)	**2013-14**	**2014-15**	
TIER	**Performance Period 2012-13**	**Performance Period 2013-14***	**DIFFERENCE BETWEEN 2013-14 AND 2014-15**
2	$ 17,501,000	$ 54,517,000	$ 37,016,000
3	$ 21,199,000	$ 26,483,000	$ 5,284,000
Total	**$ 38,700,000**	**$ 81,000,000**	**$ 42,300,000**

*As a result of the Legislative mandate to increase the GF set aside, the Rate Year 2014-15 amount available for incentive payments was $81 million, compared to $38.7 million in FY 2013-14.

Figure 9: Total QASP Program Incentive Payments, SNF distribution, and average payment per SNF.

QASP INCENTIVE PAYMENTS, SNF DISTRIBUTION, & AVERAGE PAYMENT PER SNF							
Payment Period (Rate Year)	**2013-14**			**2014-15**			
	Performance Period 2012-13			**Performance Period 2013-14**			
TIER	**PAYOUT**	**SNFs**	**AVG**	**PAYOUT**	**SNFs**	**AVG**	**AVG CHANGE**
2	$17,501,000	222	$79,000	$54,517,000	265	$206,000	$127,000
3	$21,199,000	213	$100,000	$26,483,000	99	$268,000	$168,000
Total	**$38,700,000**	**435**	**$89,000**	**$81,000,000**	**364**	**$223,000**	**$134,000**

IV. IMPROVEMENT PAYMENTS

Improvement Payments were developed to recognize SNFs that improve quality from the previous year by awarding those facilities that show the greatest improvement year-over-year. The Improvement Payment award is available to some SNFs that may not yet be eligible for Incentive Payments. In consultation with various stakeholder groups, DHCS and CDPH agreed to use the same quality measures and scoring system described above, to measure improvement year-over-year.

Below is the improvement scoring methodology used to award QASP Program Improvement Payments:

1. Obtain data from SNFs for purposes of scoring.

2. Obtain Improvement Score per SNF by analyzing data (current year total Quality Measures Score minus the previous year's total score).
3. Rank each SNF from highest to lowest score
4. Select top 20th percentile to receive Improvement Payments.

Figure 10: Example illustration of scoring methodology for Improvement Payments with the line between ranking 2 and 3 reflecting the 20th percentile cutoff point.

RANK	Facility	Current Score		Prior Year		Improvement Score	
1	A	65	minus	45	=	20	**Receives payment**
2	B	44	minus	25	=	19	
3	C	52	minus	35	=	17	
4	D	50	minus	34	=	16	
5	E	56	minus	42	=	14	**Does Not**
6	F	49	minus	35	=	14	**Receive**
7	G	46	minus	33	=	13	**Payment**
8	H	64	minus	51	=	13	
9	I	48	minus	36	=	12	
10	J	67	minus	57	=	10	

Figure 11: Step by step calculation for average payment to SNF.

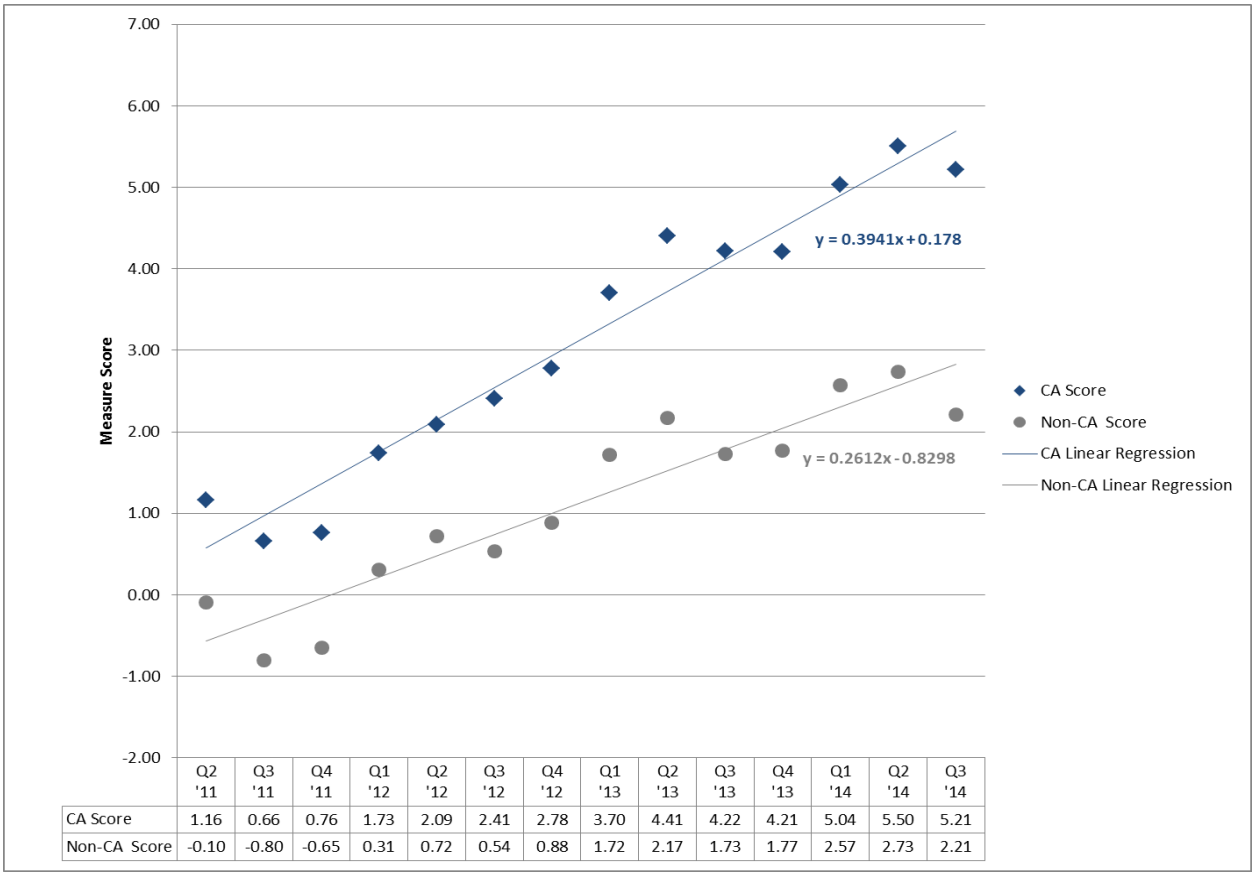
QASP Program Improvement Payments		
Payment Period (Rate Year)	**2013-14**	**2014-15**
Performance Period	**2012-13**	**2013-14**
Total Payments	**$4,300,000**	**$9,000,000**
Improvement Top Percentile	20th	20th
SNFs Qualifying for Improvement Payments	225	185
Payment per Medi-Cal Bed Day	$0.91	$2.16
Total Medi-Cal Bed Days	4,702,001	4,159,002
Average Medi-Cal Bed Days per Facility	20,898	22,481
Average Payment per SNF	**$19,111**	**$48,648**

Figure 12: MDS measurement areas and their quality measures for SNFs; FY 2011-12 through FY 2013-14.

	SNF Statewide Averages		
Payment Period (Rate Year)	**Baseline**	**2013-14**	**2014-15**
MDS Quality Measures for SNFs	**2011-12**	**2012-13**	**2013-14**
Pressure Ulcers			
Pressure Ulcers: Long Stay	4.25%	3.74%	3.85%
Pressure Ulcers: Short Stay	1.87%	1.72%	-

Physical Restraints			
Physical Restraints: Long Stay	3.97%	2.64%	1.69%
Immunizations			
Influenza Vaccination: Long Stay	91.02%	92.35%	-
Influenza Vaccination: Short Stay	78.42%	80.54%	81.34%
Pneumococcal Vaccination: Long Stay	93.89%	94.20%	-
Pneumococcal Vaccination: Short Stay	77.38%	79.28%	79.86%
Urinary Tract Infection			
Urinary Tract Infection: Long Stay	-	-	4.84%
Control of Bowel/Bladder			
Control of Bowel/Bladder: Long Stay	-	-	46.07%
Self-Report Moderate to Severe Pain			
Self-Report Pain: Short Stay	-	-	15.39%
Self-Report Pain: Long Stay	-	-	6.99%

Figure 13a: The below analysis shows the rate of quality improvement using a composite measure which combined all 17 measures that were available from the Nursing Home Compare database between Q2 2011 and Q3 2014. This analysis calculated an aggregate score for each quarter, allowing for a comparison of overall improvement between the California and non-California median rates. For the aggregate score, a higher score reflects better performance.



	Q2 '11	Q3 '11	Q4 '11	Q1 '12	Q2 '12	Q3 '12	Q4 '12	Q1 '13	Q2 '13	Q3 '13	Q4 '13	Q1 '14	Q2 '14	Q3 '14
CA Score	1.16	0.66	0.76	1.73	2.09	2.41	2.78	3.70	4.41	4.22	4.21	5.04	5.50	5.21
Non-CA Score	-0.10	-0.80	-0.65	0.31	0.72	0.54	0.88	1.72	2.17	1.73	1.77	2.57	2.73	2.21

Based on the analysis, the California aggregate scores are improving at a significantly faster rate than the non-California aggregate scores, with a rate improvement of approximately 0.39 points per quarter compared to approximately 0.26 points per quarter for the non-California aggregate scores. Overall, California aggregate scores are improving at a rate that is approximately 50 percent faster than the non-California aggregate.

V. RESULTS

For the FY 2011-12 and FY 2013-14 time periods, there was an overall decrease in the statewide average incidence of Long Stay Pressure Ulcers and the use of physical restraints, which could indicate a trend toward quality improvement for these measures. Short stay vaccination rates also improved during these periods. Three quality measures were removed after first performance period: Short Stay Pressure Ulcers, Long Stay Influenza Vaccination and Long Stay Pneumococcal Vaccination and four quality measures were added for the second performance period: Long Stay Urinary Tract Infection, Long Stay Control of Bowel/Bladder, Short Stay Self-Report Pain, and Long Stay Self-Report Pain. Figure 12 illustrates the MDS quality measures used by the QASP Program, the performance period when measures were implemented, the length of stay variables, and the percent average of statewide SNFs that met the measures.

VI. Conclusion

The QASP program has utilized various performance measures to assess and score the quality of care provided in SNFs. Overall, for the FY 2012-13 and FY 2013-14 performance periods, there have been quality improvements made in the areas of Long Stay Physical Restraints as shown by a percentage decrease in the statewide average and an increase, from last to first, in California's ranking among U.S. states for this measure. Other areas of quality improvements were for Short Stay Influenza Vaccination and Short Stay Pneumococcal Vaccination, as shown by a percentage increase in the statewide average as well as overall improvement in how California ranks among states. Since the QASP program began, California continues to increase its quality measure rankings among US states. While this limited data is indicative of quality of care improvement through QASP incentive and improvement payments and despite preliminary analysis showing that California quality of care is improving at a statistically significant and higher rate than other states, attribution of causality cannot be fully ascribed to the QASP program. Quality improvement in healthcare is complex and involves a number of factors beyond the QASP program. Based on this complexity and, despite promising trends, the Department cannot conclude the impact of these payments is directly correlated to the effectiveness of the program.