P4P: PROGRAM DESIGN IS KEY

MEG LAPORTE

STATES ARE GRADUALLY TARGETING NURSING FACILITIES FOR MEDICAID P4P, AND PROVIDER INVOLVEMENT IS CRITICAL.

If you haven't already heard about the latest trend in health care reform today, take heed: Pay for performance (P4P), or value-based purchasing, may soon be coming to a nursing facility near you. While the concept of rewarding providers for delivering high-quality health care is relatively new to long term care, the growth of such programs has moved at a rapid pace within a variety of private health plans, employer coalitions, and public insurance programs.

And while only a handful of nursing facilities currently participate in P4P—by all accounts Medicaid agencies in four states currently have long term care-specific programs in place—within the next 18 months, the Centers for Medicare & Medicaid Services (CMS) will launch a Medicare P4P nursing facility demonstration program with "a few hundred nursing facilities" participating. The agency recently held a stakeholder meeting to obtain input from providers and advocates and plans to begin recruiting states this spring.

Growth Occurs Nationwide

Nationwide, more than 100 P4P initiatives currently exist, according to the U.S. Department of

Health and Human Services Agency for Healthcare Research and Quality. In addition, a 2005 survey of P4P sponsors found that "most physicians and hospitals in the United States currently face or are in discussions with local purchasers about some form of pay for performance."

A recent Kaiser Commission for Medicaid and the Uninsured survey of state Medicaid agencies found that in fiscal year 2007, more than two-thirds of all states will have some type of quality initiatives in place, most classified as P4P. According to the report, "Many of these initiatives use bonuses or penalties for performance that meet or fall short of specific quality criteria or include automatic managed care enrollment formulas that reward higher-performing plans with more enrollees."

During 2006, 14 states implemented specific new quality incentive programs, including 10 states that classified their new policies as P4P, while 20 states had quality incentives in place in 2005 or before.

"Discussions with Medicaid officials indicated that these programs often included financial incentives for managed care organizations or provider groups that met or exceeded specified benchmarks on a range of measures, including immunizations, prenatal care, and diabetes care management," the report says.

"The financial incentives may be a 'withhold from' or 'add-on to' the per-member, per-month capitation payment from Medicaid, bonus payments, or an algorithm to auto-assign more mandatory managed care enrollees in plans with better performance."

The enthusiasm surrounding P4P has become part of the vernacular of health care policy analysts and thought leaders, many of whom believe that P4P has the potential to transform payment systems. CMS has developed a comprehensive guide for health care P4P sponsors, while the Medicaid Commission recently advised Congress to consider tying payments to Medicaid providers to "objective measures of risk- and case-adjusted medical outcomes."

According to the commission's report, this will lead Medicaid to "become more patient-focused, that is, funding health care in a way that assures patients are getting the care they need."

Most recently, the Government Accountability Office (GAO), in a letter to congressional leaders, made several recommendations for the 110th Congress regarding "Medicare's and Medicaid's long-term fiscal sustainability for supporting health care for elderly, disabled, and low-income Americans." In the letter, GAO called on Congress to use Medicare reimbursement to reward quality and efficiency.

LAST SEPTEMBER, IOM DECLARED P4P TO BE A POTENTIALLY VIABLE STRATEGY TO ASSIST IN MENDING THE BROKEN MEDICARE PAYMENT SYSTEM.

Everyone Getting On Board

Scores of Medicare provider organizations have weighed in on the issue, including the American Health Care Association (AHCA), the American Geriatrics Society, and the American Medical Association, to name a few. Additional major Medicare policy players have issued white papers and recommendations regarding P4P, including the Institute of Medicine (IOM) and the Medicare Payment Advisory Commission. While the theory behind P4P is relatively straightforward, putting it into practice is not. In its most basic form, P4P is borrowed from a somewhat effective child-rearing technique that seeks to modify behavior by rewarding for good conduct and punishing for poor conduct.

In reality, health care P4P programs require sophisticated mechanisms for assessing and rewarding high-quality health care providers.

For example, many sponsors of P4P programs report that either rewarding or improving quality of care is a primary goal, while the other goal may be to control costs either directly or indirectly by reducing errors and inappropriate utilization.

In addition, in order to assess the performance of its providers, sponsors generally employ a combination of process and clinical outcome measures.

Advocates of the P4P concept believe that, ultimately, the use of cash incentives such as add-ons to reimbursement rates or year-end bonuses to encourage quality improvement will help alleviate two major problems plaguing the health care system today: inefficient reimbursement systems and inconsistent quality of care.

Last September, IOM declared P4P to be a potentially viable strategy to assist in mending the broken Medicare payment system. In its latest report, "Rewarding Provider Performance: Aligning Incentives in Medicare," IOM lauds the concept as "one mechanism that can help transform the payment system into one that rewards both higher value and better outcomes," but advises that "care must be

given to the design of a pay-for-performance system because it could influence far more than just payment rates."

Similar to the concerns expressed by other health policy experts, IOM cautions that P4P "constitutes one key component needed for the transformation of the health care payment system but cannot achieve this transformation alone."

However, IOM adds, P4P does offer "significant promise and can begin now by building off other strategies for improvement."

Harvard University School of Public Health Professor Meredith Rosenthal said recently to an audience of state Medicaid directors that while there is evidence that P4P can be an effective tool, "it's really one piece of an overall strategy for improving quality and affordability.

"It's important to think carefully about what you're doing to look at models out there. They may actually be the best experts about what's working. We urge you to monitor these programs, and look for…what's effective."

Potential Models

As the development of P4P programs gains momentum at the federal and state levels, current CMS Medicare P4P demonstrations may ultimately serve as models for other policy makers and purchasers. Many of these demonstrations, which are primarily in physician practices and hospitals, stem from the Medicare Modernization Act (MMA) of 2003—the same legislation that ushered in the new Medicare drug benefit.

Since the MMA called on CMS to develop and study a variety of P4P demonstrations, the agency has launched several hospital-based programs, including one in conjunction with Premier, which yielded "positive results among the 262 participating hospitals" in the first year of its existence, according to an analysis of the program.

Additional demonstrations have not yet been evaluated, but for the majority of them CMS must submit reports to Congress by 2008. Medicare's Physician Group Practice Demonstration rewards group practices for their performance on quality-of-care metrics after the practices achieve savings of at least 2 percent of projected expenditures, while the Medicare Management Performance Demonstration focuses on small- and medium-sized physician practices and promotes the use of health information technologies to improve care for the chronically ill.

The Chronic Care Improvement Program, which tests a population-based model of disease management, includes nine participating organizations that receive a monthly capitated payment rate for management of patients with specific conditions such as advanced congestive heart failure or complex diabetes.

Nursing Facilities Are Next

Dubbed the Nursing Home Quality-Based Purchasing Demonstration, CMS' nursing home P4P program is

USING ADVANCING EXCELLENCE CAMPAIGN

The stage is set, and unless providers prepare now, a golden opportunity to be fully equipped for the impending touchdown of pay for performance (P4P) in long term care may be lost.

As evidenced by the soon-to-be-launched Medicare nursing facility P4P demonstration, CMS' corresponding recruitment campaign of state Medicaid agencies, and the widespread support of P4P by policy makers and health policy analysts, the train appears to be approaching, and it's just a matter of time before it reaches its destination.

How Campaign Aligns With P4P

One way that providers can prepare for P4P implementation is through the national Advancing Excellence in America's Nursing Homes campaign.

First, as one of CMS' most widely supported nursing facility quality improvement initiatives, Advancing Excellence is purposefully designed around quality measures and goals that are in effect a continuation of Quality First, an initiative developed by AHCA, the Alliance for Long Term Care, the American Association of Homes and Services for the Aging, and the CMS Nursing Home Quality Initiative. In fact, the Advancing Excellence goals are derived from or correspond to the measures developed for previous campaigns.

Second, the measures chosen by CMS for its nursing facility P4P demonstration are strikingly similar to the Advancing Excellence goals. The measures have been designed to encompass quality of care, such as staffing, appropriate hospitalizations, resident outcomes, and survey deficiencies.

Finally, in its recent analysis of the CMS nursing facility P4P demonstration, Abt Associates recommends the use of quality measures from Nursing Home Compare for the demonstration.

At the state level, the Iowa Accountability Measures

set to launch in 2008. It will assess the performance of nursing facilities based on selected measures of quality of care, such as staffing, appropriate hospitalizations, resident outcomes, and survey deficiencies, according to CMS.

In addition, CMS reports that the demonstration is intended to ensure that "financial investments made by nursing homes to improve quality will be met by payment methods that can discern the difference between excellent, good, mediocre, and poor quality."

Speaking at a recent Medicare conference, Sheila Lambowitz, CMS director of the Chronic Care Policy Group, Division of Institutional Post-Acute Care, explained that the demonstration will cover both Part A and Part B patients.

Since Part A utilization for most nursing facilities is only 15 percent of the total, she said, "most of the patients are Medicaid, and to try to set standards for such a small portion of the operations could have results we really don't want. It could really establish a two-tier system so that the Part A patients get better care if you're on Medicare."

How Measures Were Chosen

In describing the measures, Lambowitz noted that she and her colleagues intentionally avoided choosing too many measures. "We tried not to come up with 450 different criteria for performance, because nobody can concentrate on that many things at one time," she said. "We do have staffing because I think everyone can see there is an [obvious] relationship between staffing and care."

The selection of a hospitalization measure was based on data showing that the rate of re-hospitalization in nursing facilities is extremely high. "We don't know if that is a function of nursing home protocols or hospital discharge protocols, or possibly the incentives in our skilled nursing facility payment system, which bundles services in the nursing home but unbundles them if you send the person to the hospital for a few days," she said.

"So we ended up taking a gross measure. We will look at what the hospital rate was the year before the demo started, and if it was 40 percent and you reduced it to 35 percent we consider that a savings. We may be able to get some analytic data to show what conditions seem to be most susceptible to hospital avoidance, but we're not going to be that detailed: We're just going to look at the rates."

Funding of the demonstration, in order to pay for the nursing facility "incentives," will come from Medicare savings as a result of quality improvements, while "facilities with serious deficiencies would be disqualified from receiving any incentive payment," according to the demonstration's draft design report posted on the CMS Web site.

Abt Associates, a CMS consultant contractor, recently advised against such a restriction in a report to the agency on the nursing facility P4P demonstration. "A concern about reducing payments to poor performers is that these providers may have few

TO PREPARE FOR P4P

Program for nursing facilities, which is believed to be the first of its kind among state Medicaid agencies, has recently considered the addition of clinical measures to its program. To that end, the state is working with the Iowa quality improvement organization to study CMS' existing quality measures.

In addition, a recent evaluation of the Iowa program included a recommendation that the "system might be expanded to include other accountability measures such as nursing home quality indicators that focus more directly on delivery of care."

Some health care policy experts have seen the value of utilizing established measures to support P4P programs.

Speaking at a recent gathering of state Medicaid directors, Harvard University Professor Meredith Rosenthal suggested that since Medicaid data from nursing facilities "is substantial, and increasingly there are good data from CMS and other places, [it may be useful] to track the performance of nursing homes on quality of care and use that information for P4P."

What appears to be a deliberate effort to prepare providers for P4P could turn out to be merely speculative. However, CMS and other payers are looking for ways to transform the payment systems and improve quality of care, and P4P has been widely touted as a key strategy in any effort to make this change.

reserve resources, and the reduced payment may force them to reduce their quality of care or force them out of business," the report says.

CMS is also soliciting state Medicaid agencies to join it in "operating the same incentive programs for their Medicaid patients, so that we [will] have probably 90 percent of payments under that same incentive structure," says Lambowitz. To that end, CMS sent a letter to state Medicaid directors informing them that states that partner with the agency on the P4P demonstration "will have the advantage of testing a program that has the potential of improving quality of care.

"The state would also have the opportunity to receive technical assistance on program design from national experts in the field and have an opportunity to shape the design prior to any national rollout," the letter says.

States Initiate P4P Medicaid Programs

While only a handful of state Medicaid nursing facility payment incentive programs are under way, the cadre of existing programs may serve as models for other states considering similar programs. Iowa, Kansas, Ohio, and Vermont currently have payment incentive programs specifically for nursing facilities. In addition, Abt Associates reports, Minnesota has designed, but not yet implemented, a value-based system, while Colorado and North Carolina are considering such programs for the future. Several state quality-based purchasing programs in California, Illinois, Massachusetts, New York, and Texas were reported to be no longer active.

According to Abt, these state payment incentive programs have used a variety of performance measures, including quality indicators derived from the minimum data set (MDS), staffing levels and staff turnover and retention, measures of resident satisfaction and quality of life, the adoption of culture change initiatives, and deficiency citations or other survey outcomes.

The state P4P programs consulted for this article—Iowa, Kansas, and Ohio—were all developed in collaboration or with direct input from their respective state AHCA affiliates, a detail that appears to have played out as a critical element in the development of the programs' measures.

In Iowa, for example, it has not gone unnoticed by Mary Jane Vantiger, administrator of Thomas Rest Haven Nursing Center, Coon Rapids, that the Iowa Health Care Association (IHCA) was instrumental in developing the state's Nursing Home Accountability Measures program.

"I thought it was a terrific win for our profession when we negotiated with the [state]," she says. "It gives us more incentives with the staff because it could mean the difference between [whether or not we could provide] a raise for staff."

Vantiger also says that Iowa's program has been a very positive experience for her and her facility. "It's a great carrot to put in front of the providers," she says.

According to Jennifer Steenblock,

IOWA'S ACCOUNTABILITY MEASURES

Iowa's Accountability Measures Program utilizes 10 measures to determine the annual level of remuneration for each facility. Beginning with rates effective July 1, 2002, the case-mix portion of a facility's Medicaid rate included an additional payment component for these measures.

Eligible facilities in the state were notified of the program in a letter from the state's Long Term Care Program office, which described the program's measures and characteristics as "objective, measurable, and, when considered in combination with each other, were deemed to have a correlation to a resident's quality of life and care."

Today, out of 425 nursing facilities in Iowa, 354, or 83 percent, are receiving some type of an add-on, based on where they score on the measures.

Nursing facilities must achieve a minimum score of 3 points (out of a possible 10) in order to qualify for additional Medicaid reimbursement under the program. Achievement of each measure is based on a facility's data compared with the state's established criteria.

Facilities opting to apply for the optional resident opinion (or customer satisfaction) survey measure must distribute a standardized form to residents within the facility for completion anytime between September and December of each year. Once the surveys are completed, they are returned to an independent party, which reviews the completed forms, tabulates the individual survey scores, and transmits the results to Iowa's Office of Human Services.

The Measures

■ Measure 1: Deficiency-free survey (point value of 2). Based on the latest annual survey completed on or before Dec. 31 of each previous year and any subsequent surveys completed between the annual survey date and Dec. 31 of the same year.

■ Measure 2: Substantial compliance with survey (point

Iowa's Long Term Care Program manager, the state was the first to implement a nursing facility accountability measures program. "In the last five years we've been contacted by many other states and other entities telling us that from their research we've been the first state to develop a P4P-type program or enhanced payment based on quality for nursing homes," Steenblock says.

The program, which was launched in July 2002, has been quite successful by all accounts, especially since it was done concurrently with the state's conversion to a new payment system and was backed by the legislature.

"We had a legislative mandate to develop and implement a case-mix reimbursement system, and the same legislation also directed Iowa Medicaid to initiate and develop a system to measure a variety of elements to determine a nursing facility's capacity to provide quality, cost-effective services," Steenblock says.

"So what we needed to do was implement a process to collect data for measures that would be developed, that would result in increase payment to nursing facilities based on achievement of multiple favorable outcomes."

Providers Must Participate

Stakeholder involvement was absolutely key to the development of the program and its measures, according to Steenblock.

"It helped get the buy-in on the program we were developing. And, of course, there was a real balance we had to strike [within the task force] because…on one side the providers wanted to make sure the [measures] were reachable, while at the same time the advocates were a little more cautious in wanting to make sure that the measures were something that facilities were really going to earn," she says. "There was a real balance we had to strike, but I think we did that working with a cohesive work group during the many months of development."

Steenblock's advice to other states embarking on a similar process: "It's key to work in collaboration with the industry, the agency stakeholders, and advocacy groups," she says. "And I think the fact that we had legislative support, that it was initiated by the legislature, helped it along. I don't think that it would have been as well received if the department had maybe presented it on its own. I think that it helped the project to move ahead."

Indeed, IHCA was so entrenched in the development of the measures that Cindy Baddeloo, IHCA's deputy director, wrote her PhD dissertation on the process.

Following implementation of the program, reaction of IHCA members was "all very supportive," she says, pointing out that the association was successful in removing an initial component of the program that would have deducted from reimbursement for poor outcomes on the measures.

value of 1). Based on the latest annual survey completed on or before Dec. 31 of the previous year and any subsequent surveys completed between the annual survey date and Dec. 31 of the same year.

■ Measure 3: Nursing hours provided (point value of 2 for nursing facilities at or above 3.691), based on a nursing facility's case mix-adjusted nursing hours per patient day. For nursing facilities with nursing hours per patient day at or above 3.204 hours (50th percentile) and below 3.691 hours (75th percentile), the point value is equal to 1.

■ Measure 4: Resident satisfaction (point value of 1 for nursing facilities with an average score of 4.066—50th percentile or greater). Measured using the Resident Opinion Survey form.

■ Measure 5: Resident advocate committee resolution rate (point value of 1). Nursing facilities that have a resident advocate committee resolution rate of 60 percent or greater.

■ Measure 6: High employee retention rate (point value of 1). Nursing facilities that have an employee retention rate of 72.7273 (50th percentile).

■ Measure 7: High occupancy (point value of 1). Nursing facilities with occupancy at or above 95 percent.

■ Measure 8: Low administrative costs and low utilization of contracted nursing (point value of 1). Facilities with per patient day administrative costs of $10.82 (50th percentile) or less and no contracted nursing (50th percentile).

■ Measure 9: Special licensure classification (point value of 1). Nursing facilities with units licensed for the care of residents with chronic confusion or dementing illness.

■ Measure 10: High Medicaid utilization (point value of 1). Facilities with Medicaid utilization at or above 50.41 percent.

Iowa's accountability measures do not apply to Medicare-certified, hospital-based nursing facilities; state-operated nursing facilities; or special-population nursing facilities.

Education was also central to the successful implementation of Iowa's program for the state's nursing facilities themselves, according to Vantiger, who notes that her facility's reimbursement consultant was active in educating members about the new case-mix system. "[IHCA] was very good about educating us on the system as well," she says.

The new program forced Vantiger and her staff to take a critical look at the facility's systems, with the help of a consulting firm. "We made sure that all staff knew what the system was about, what it meant, and how it affected their work. We really got their buy-in," she says.

"In preparing for the implementation of the program, we tried to look at employee turnover. We were also very cognizant of survey outcomes," says Vantiger, who notes that as a result of her scrutiny of the state cost reports, she caught an error that the state had made regarding her facility's latest survey outcomes. Had she not caught it, "we never would have received the credit for it or the $9,000 bonus."

Vantiger also learned that capturing the appropriate MDS indices for patients was vital to getting appropriate scoring for the quality incentives. "The behaviors, if not coded correctly, could have made our quality indicators look bad, but when we looked at the definitions [of indices] on the MDS more closely, we realized we weren't coding correctly. We carefully review those areas, because if it's not accurately captured in the MDS, you won't get scored appropriately, and you want to make sure we are capturing these people."

Steenblock recalls that development of the 10 measures was a guarded process because "we didn't have funding for any new data. Basically, we had to go with data that already existed out there and was easy for us to capture and analyze." As a result, Steenblock notes that the measures were derived from the financial state cost reports, the MDS, and survey outcomes reports. "But we automatically pull that information so there's no extra reporting on the part of the facility for us to calculate and tabulate—it's already on the report."

Much of the research and expense related to development of the measures was focused on development of the resident satisfaction survey, which was ultimately modeled after an instrument created by the University of Oregon.

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Collaboration Essential

Having amassed three years of data from the accountability measures program, Iowa contracted with a consultant to conduct a preliminary analysis of the program. "The analysis does show us that there are some indications that facilities are improving and that the medians are going up," says Steenblock. "And so now our work group convened last month to start digging a little deeper, based on the analysis that was done. It shows that there are some correlations between some measures, so we want to take the accountability measures to the next level and ask, 'Are there some major modifications we want to make now that we're five years into it?'"

In fact, Steenblock says, the state is considering the introduction of clinical measures into the program. "We are working with our quality improvement organization, the Iowa Foundation for Medical Care, and they will present at our next work group meeting…on what's going on with the nursing home quality initiative and some other quality programs that CMS is involved in. We will try to look at some of the clinical measures that are already being reported and see if maybe they can be built into the Iowa accountability measures process."

Steenblock notes that at the time the measures were developed, the CMS Nursing Home Quality Initiative project was just under way. "When we were starting to develop this there was a lot of talk about being able to add some clinical outcomes. But we just couldn't do it at the time. The clinical measures are definitely something of interest."

From The State's Vantage

In response to the question of how the state may have benefited from the process, Steenblock is positive, but she points out that the program was not set up as a cost-saving initiative.

"I think that there's an indication that nursing homes are interested in quality and they are interested in achieving these multiple favorable outcomes. We are seeing…that nursing homes are interested in providing quality care, sufficient care, and having a commitment to serve special populations," she says.

"We're seeing that folks are genuinely interested in how they're doing with the accountability measures. When we issue the measures each year, we have facilities call us, they ask questions, they want to understand 'why

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did I not qualify for this one?' They genuinely want to understand the program and what it means to them. We have seen that the incentives provided by the accountability measures have motivated providers."

Steenblock has been very cautious to not post the measures publicly because "no single measure ensures a quality facility or a good facility. We don't want it to be compared to a report card for facilities when family members or consumers may be shopping for a nursing facility. We've been cautious that we don't want this to be confused with report card information," she says.

Ultimately, Steenblock says she is satisfied with where the program has gone and where it is today. However, she adds, "I would think that maybe one thing we would have done differently would be having some sort of appropriation to assist us in the development of the accountability measures because we had to develop a pretty simple system [with] information that was already reported."

Ohio and Kansas each borrowed heavily from elements of the Iowa Accountability Measures to develop their own value-based purchasing programs. And similar to Iowa's experience, each state's AHCA affiliate found that involvement in the process was crucial not only to the buy-in of their members, but also to the creation of the quality measures.

Kansas, Ohio Programs

The Kansas Health Care Association (KHCA) proved this point with its successful elimination of a measure that used survey deficiencies to calculate a facility's potential add-on. "They used to give incentives for a zero-deficiency survey," says KHCA Executive Director Cindy Luxem. "But we were successful in convincing the Department on Aging that it needed to be removed, primarily because at that time Kansas was participating in a CMS pilot survey project, and very few people were receiving deficiency-free surveys. It shouldn't be a factor or incentive to have survey added into that. The Department on Aging saw that it was really not dependent on how someone's quality was in the home."

Luxem, who notes that the Kansas Quality Incentive Program was launched in July 2006, says that KHCA has always been involved in the program's development process.

"We've always been involved in the discussions, not that they always listen to us, but the response has been positive."

For other states considering a P4P program, Luxem advises that good working relationships with the legislature and the administration are important for providers to get their input heard.

"I think what we've found is, overall, the Department on Aging is supportive of our providers. They want not only to have good providers, but they want to reward those providers for doing a good job," she says. "And I don't think there's anything wrong with P4P or incentive factors as long as it's enabled everyone to sit down at the table and discuss and figure out what the best consensus is for what needs to be looked at."

Ohio Health Care Association (OHCA) President and Chief Executive Officer Peter Van Runkle is just a few months into the launch of his state's quality incentives payment program, but his organization's work on the program began nearly six years ago with the development of a customer satisfaction survey that ultimately became one of the measures in the quality incentive program.

"Pay for performance wasn't even a concept when we started," says Van Runkle.

"It didn't come in until about 2004. When we started having discussions about that…one of the things we insisted on was that the customer satisfaction information be a part of it—no one was really opposed to it."

OHCA's involvement in other aspects of the program's development also proved successful. Van Runkle wanted to be sure that there was no incentive on the part of the state to withhold funds that are designated specifically for the program. "We devised a process that uses all the dollars," he says.

"What we did was [ensure that the] average quality incentive payment has to be $3 per day. The magic of it is that if there were fewer points that all the facilities in the state got, it would mean that each point would be worth more.

"If there are more points each point is worth less, but whatever it is, it's all got to work back to $3 a day. They can't reduce the amount of dollars being paid out."

Today, Van Runkle reports that his constituency is happy with the outcome. "There are always issues but, by and large, the profession supports the

idea of satisfaction being a key measure for provider quality," he says.

Cautious Optimism

While these three state provider organizations appear to be happy with their P4P programs, most health care experts agree that the concept is still in the exploratory phase in this country. They advise that P4P should be part of a larger health reform effort and not the sole driver.

Adding to this concern is the fact that adoption of electronic health records among health care providers is sluggish, which does not bode well for efficiently reporting data on quality measures.

And although IOM called on Medicare to implement programs in institutions immediately, the committee did acknowledge that for skilled nursing facilities (SNFs), adequate measures are not yet available. "Until such measures are available, implementation should proceed in a manner similar to others settings, where pay for public reporting precedes P4P," the report says.

AHCA is similarly apprehensive about the impending Medicare P4P demonstration. In comments to CMS, the organization said that "the literature is rife with expressions of concern on the part of quality and payment experts. Perhaps 10 years from now, we will hail P4P as a fundamental breakthrough in encouraging better quality, or it will have fallen short of its expectations but, at a minimum, may prove to be a constructive step on the road to a profoundly different and more comprehensive approach to all post-acute care." Also included in the comments were AHCA's principles for guiding the development of nursing facility P4P programs:

■ That appropriate and meaningful risk-adjusted and validated quality measures and standards must be developed by CMS with the industry;

■ That the application of P4P for SNFs should be phased in over a reasonable time period to allow underperforming facilities to improve their quality before they begin being penalized;

■ That initial incentives for participation should start at a low percentage and increase over time in order to deal with the impact of the phase-in to ensure compliance with budget constraints; and

■ That SNF pay-for-performance methodology and measures should first be tested prior to full implementation, and testing should be representative of all types and sizes of facilities in all states. ■

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