Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

October 24, 2019

The Honorable Nancy J. King
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2019 Joint Chairmen's Report (p. 115) – Report on Nursing Home Quality Program

Dear Chairs King and McIntosh:

Pursuant to the 2019 Joint Chairmen's Report (p.115), the Maryland Department of Health submits the enclosed report on a plan to increase the size of the nursing facility quality program, refocus the program on reportable outcomes, and also include incentives and disincentives. Specifically, the report added the following language to the general fund appropriation:

> *Further provided that $500,000 of this appropriation made for the purpose of nursing home provider reimbursements may not be expended until the Maryland Department of Health submits a report to the budget committees on a plan to implement, beginning in fiscal 2021, a nursing home quality program valued at least at 1% of the total nursing home provider reimbursements that is patient outcome-specific and includes a system of incentives and penalties. The report shall identify outcomes to be included in the program as well as the mechanism for providing incentives and disincentives.*

Thank you for your consideration of this information. If you have questions about this report, or would like additional information, please contact me or my Chief of Staff Tom Andrews at (410) 767-0136 or thomas.andrews@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Background

SB 101 from the 2007 legislative session authorized the Department to initiate a quality assessment on certain nursing facilities in Maryland, in order to restore cost-containment reductions to nursing facilities in the Maryland Medical Assistance Program (Medicaid). It was also established under SB 101 that a portion of the revenues generated by the assessment shall be distributed to nursing facilities based on accountability measures that indicate quality care or a commitment to quality of care.

The Department convened a workgroup that developed a pay-for-performance (P4P) model for Maryland nursing facilities.

In 2008, HB 809/SB 677 delayed implementation of the P4P model until July 1, 2009. Facilities were scored, and providers were notified of the results and incentives they would have received, but no funds were distributed. During the 2009 legislative session, HB 782/SB 664 further delayed the distribution of incentive payments to nursing facilities until July 1, 2010. Beginning July 1, 2010, 50 percent of the funds designated under the model were distributed based on the quality measures established. A payment for improvement component was also implemented at that time. Incentive payments were fully implemented effective July 1, 2011.

The Current P4P Model

Per SB 101, continuing care retirement communities and facilities with fewer than 45 beds are not subject to the quality assessment and, consequently, are not eligible for participation in P4P. In addition, facilities that meet the following criteria during the 1-year period ending March 31 of each year are also excluded from P4P for that year:

1. Any facility identified by the Centers for Medicare and Medicaid Services as a "special focus" facility.
2. Any facility which has had a denial of payment for new admissions sanction imposed by the Office of Health Care Quality (OHCQ).
3. Any facility which has been identified by OHCQ as delivering substandard quality of care.

Quality measures chosen for use in P4P are as follows:

- Staffing Levels and Staff Stability in Nursing Facilities (40%)
- Maryland Health Care Commission Family Satisfaction Survey (40%)
- MDS Clinical Quality Indicators (16%)
- Employment of Infection Control Professional (2%)
- Staff Immunizations (2%)

Each facility receives a composite score that determines the facility's rank and subsequent amount of payment per Medicaid patient day. The highest scoring facilities representing 35 percent of the eligible days of care receive a quality incentive payment. In addition, facilities that do not receive a P4P incentive payment, but whose scores have improved from the prior year, receive pay-for-improvement monies.

Scoring

For scoring the elements of the family satisfaction, staffing, and MDS quality indicators, the highest ranking facility receives 100 percent of the points available. The median score, weighted by total days of care, receives 50 percent of the points available. Zero points are received by any facility whose raw score is below the median by an amount equal to or greater than the difference between the highest score and the median score. All other facilities receive points proportionate to where their score falls within the range between the highest and zero.

Facilities that meet minimum COMAR requirements for employment of an infection control coordinator receive 1 point. Facilities receive 2 points if, in a facility with 200 or more beds, an infection control coordinator is dedicated at least 35 hours per week to infection control responsibilities, or, if fewer than 200 beds, 15 hours per week.

Facilities receive 2 points if at least 80 percent of staff, which includes all staff classifications, are vaccinated against seasonal influenza.

Payment Distribution

One half of 1 percent of the budget allocation for nursing facility services is distributed based on P4P scores. Eighty-five percent of this amount is distributed to the highest scoring facilities representing 35 percent of the eligible days of care. Funds are distributed based on the facility's relative score such that the highest-scoring facility receives twice the amount per Medicaid day as the lowest-scoring facility receiving payment.

The remaining 15 percent of the allocation is distributed to facilities that improved, based on the facility's relative point increase from the prior year, such that the facility with the greatest point increase receives twice the amount per Medicaid day as the facility with the smallest point increase.

The Proposed Model

In order to address the requirement of the Joint Chairmen's Report, the Department convened a workgroup to review and recommend updates to the current P4P model. (Workgroup participants are listed on Attachment A.) Four meetings were held during July, August, and September of 2019. There was general agreement that the current model established a reasonable basis from which to work. The model contains multiple elements and data sources that build an overall picture of quality. The workgroup focused on each of the quality measures as follows:

Staffing Levels and Staff Stability

In the current model, it is established that the optimum staffing level is 4.13 hours per resident per day for a facility with an average acuity. A target staffing level is adjusted for each facility with higher or lower than average acuity based upon Minimum Data Set Resource Utilization Groups (RUGs). Facilities that meet their target staffing level receive 20 points; facilities receive 0—20 points based on the scoring methodology described above.

Staffing levels are currently measured based on a wage survey of nursing service staff conducted by the Program annually. Hours of work data for selected personnel types are collected for a 2-week pay period, usually around October of each year.

The workgroup recommended retaining staffing levels as a component of the P4P methodology. The group, however, discussed an alternative approach to collecting hours of work information using payroll-based journal (PBJ) data completed by providers. Although comparison of wage survey and PBJ data showed differences, both positive and negative across facilities, it was concluded that the PBJ was likely to be more accurate because it measured staffing for every day of the year rather than during a 2-week snapshot. It was agreed that it is reasonable to use available PBJ data for the first 3 quarters of the State fiscal year for scoring purposes.

Staff stability is measured by determining the percentage of nursing staff employed by the facility 2 years or longer. This element recognizes that long-term staff may be more experienced, more knowledgeable of the facility and the residents, and that a higher proportion of long-term staff will improve quality (and perhaps provide quality care more efficiently and therefore may offset a reduced staffing level). Staff stability is determined from the line on the annual wage survey that asks for the hire date of the employee. It was discussed that, if we were no longer using the wage survey for staff hours, the annual wage survey could be eliminated, reducing an administrative burden on providers and on the State. Staff longevity could be collected through a much simpler questionnaire that provides the hire date for each person on payroll. (The current audit contractor, Myers and Stauffer LC, does this in another state.) With this change, the workgroup recommended retaining the staff stability component of the P4P model, but reducing the maximum score from 20 points to 15 points.

<u>Family Satisfaction Survey</u>
The workgroup reviewed the family satisfaction survey currently conducted annually by the Maryland Health Care Commission. Since the inception of the P4P model, there have been slight modifications in the survey.

In the current model, providers may receive up to 10 points for each of two questions on overall experience. (Would you recommend this nursing home? How would you rate the care at this nursing home on a scale of 1 to 10?) Providers may also receive up to 4 points for each of five domains which are comprised of multiple questions:

- Staff and Administration of the Nursing Home
- Care Provided to Residents
- Food and Meals
- Autonomy and Resident Rights
- Physical Aspects of the Nursing Home

A total of 40 points are therefore available based upon survey results.
Two new domain categories have been added in the revised survey:

- Activities
- Security and Resident’s Personal Rights

The workgroup agreed that the questions on overall experience should be retained, as well as the original five domains. It was also agreed that the domain score for Activities should be included but, after discussion, it was decided that the domain score on Security could impact facilities differentially based on location and would not be considered.

In the proposed model, up to 6 points for each of the two overall experience questions would be allowed, and up to 3 points for each of six domains. The maximum points based on the survey results is therefore reduced from 40 points to 30 points.

MDS Clinical Quality Indicators

In the current model, the following quality indicators for long-stay residents from the resident assessment data, or "Minimum Data Set" (MDS), are used to measure clinical outcomes:

- Percent of High-Risk Residents Who Have Pressure Sores
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents with a Urinary Tract Infection
- Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season
- Percent of Long Stay Residents Who Were Assessed and Given Pneumococcal Vaccination

This component accounts for 16 percent of the total score, with each indicator accounting for up to 2.67 points.

The consensus among the Workgroup members is that physical restraints is now a nonissue, as the facilities no longer use physical restraints. This criterion will be dropped. It was agreed that an additional indicator should be added:

- Percent of Residents with a Fall Resulting in Major Injury

In the interest of placing more emphasis on clinical outcomes, each of the indicators will account for up to 5 points, increasing the maximum from 16 points to 30 points.

Employment of Infection Control Professional

Although there is no dispute regarding the importance of the role of the Infection Control Professional in the facility, there is general compliance with OHCQ regulations regarding this matter, and it is no longer a meaningful way to differentiate facilities. (Any noncompliance would be a matter for OHCQ's attention.) This quality measure, accounting for 2 points in the current model, will be dropped.

Staff Immunizations

Vaccination of nursing facility staff (all classifications) against influenza remains an important measure impacting the health of the resident population. In the current model, facilities that have at least 80 percent of staff immunized receive 2 points. In the proposed model, facilities that have

at least 90 percent of staff immunized will receive 2 points. Facilities that have at least 95 percent of staff immunized will receive 5 points.

Scoring Summary

A chart summarizing the scoring differences between the current P4P model and the proposed model is included as Attachment B.

The scoring methodology for family satisfaction, staffing, and MDS quality indicators, will remain unchanged. (I.e., the highest ranking facility receives 100 percent of the points available, the median scoring facility receives 50 percent of the points available, and any facility whose score is below the median by an amount equal to or greater than the difference between the highest score and the median score, receives zero points. All other facilities receive points proportionate to where their score falls within the range between the highest and zero.)

Payment Distribution

In accordance with the recommendation within the Joint Chairmen's Report, the Department will propose that 1 percent of nursing home provider reimbursements will be distributed based upon performance measures beginning in Fiscal Year 2021. Eighty-five percent of this amount will be distributed to the highest-ranking facilities, however, it will be allocated among those facilities representing 40 percent (rather than 35 percent) of the eligible days of care.

The Department will continue to 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. These funds will be distributed consistent with the current methodology. Although the scoring model to be used in Fiscal Year 2021 will be revised, differences in the model will not be considered. A higher score under the new, improved model compared with the score under the previous model, will be recognized as improvement.

There will be no changes in the eligibility criteria for Pay-for-Performance. The fact that funds for performance and improvement are carved out of the budget allocation for nursing facility services and distributed to qualifying providers, establishes a payment incentive and, in effect, a "penalty" for providers whose performance does not meet established criteria.

P4P Model

Current Item/Source	Current Score %	Proposed Item/Source	Proposed Score %
Staffing Levels			
Goal 4.13 hrs (avg mix), Acuity Adjusted	20	Goal 4.13 hrs (avg mix), Acuity Adjusted	20
Wage Survey		Payroll-Based Journal	
Staff Stability			
% Employed ≥ 2 yrs	20	% Employed ≥ 2 yrs	15
Wage Survey		MSLC Survey	
Family Satisfaction			
Overall Care Rating	10	Overall Care Rating	6
Recommend Facility	10	Recommend Facility	6
Staff & Administration	4	Staff & Administration	3
Physical Aspects	4	Physical Aspects	3
Autonomy, Resident Rights	4	Autonomy, Resident Rights	3
Care Provided	4	Care Provided	3
Food & Meals	4	Food & Meals	3
		Activities	3
Total Family Satisfaction	40		30
MDS			
% High-Risk Residents w/Pressure Sores	2.67	% High-Risk Residents w/Pressure Sores	5
% Residents Physically Restrained	2.67		
% Residents with Catheter	2.67	% Residents with Catheter	5
% Residents with UTI	2.67	% Residents with UTI	5
% Long-Stay Residents - Flu Vaccine	2.67	% Long-Stay Residents - Flu Vaccine	5
% Long-Stay Residents - Pneumococcal Vaccine	2.67	% Long-Stay Residents - Pneumococcal Vaccine	5
		% Residents with Fall/Major Injury	5
Total MDS	16		30
Infection Control Professional	2		
Staff Immunizations (80%)	2	**Staff Immunizations (90%, 2 pts; 95%, 5pts)**	5

Attachment A

2019 PAY FOR PERFORMANCE WORKGROUP MEMBERS

NAME	REPRESENTING
Mark Leeds	Maryland Department of Health (MDH), Office of Long Term Services and Supports
Jane Sacco	MDH, Office of Long Term Services and Supports
Lisa Jones	MDH, Office of Long Term Services and Supports
Albert Safi	MDH, Office of Long Term Services and Supports
Raquel Robinson	MDH, Office of Finance
John Dresslar	Myers and Stauffer LC
Joe DeMattos	Health Facilities Association of Maryland
Paul Miller	LifeSpan Network
Judy Schiavi	Schiavi, Wallace, and Rowe
Dawn Edwards	Genesis Healthcare
Paula Franklin	Genesis Healthcare
Rick Fink	Genesis Healthcare
Brian Finglass	FutureCare
Steven Carrico	CommuniCare
Brian Falkler	Fundamental
Heidi Trimble	Fundamental
Margie Heald	Office of Health Care Quality
Kate Ricks	Voices for Quality Care
Jen Brock-Cancellieri	1199 SEIU-United Healthcare Workers East
Eric Shope	Health Facilities Association of Maryland
Stevanne Ellis	Maryland Department of Aging
Wayne Brannock	Lorien Health Systems
Stacy Howes	Maryland Health Care Commission
Bruce Sun	Hilltop Institute
Heather Saunders	MDH, Infectious Disease Epidemiology & Outbreak Response Bureau