STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 229
August 16, 2010

To: Nursing Home Administrators

From: Susan J. Tucker, Executive Director
Office of Health Services

Note: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

Re: 2010 Nursing Home Pay-for-Performance Scores

The purpose of this transmittal is to provide nursing facilities in Maryland with the 2010 pay-for-performance (P4P) results.

SB 101 from the 2007 legislative session authorized the Department to initiate a quality assessment on certain nursing facilities in Maryland, based on non-Medicare patient days of service, in order to restore reimbursement cuts to nursing facilities in the Medicaid program. In accordance with the legislation authorizing the Nursing Facility Quality Assessment, a portion of the revenue 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. Under the provisions of HB 782/SB 664 (2009), the P4P program is being implemented on a phased-in basis in FY 2011. Funds are to be distributed in accordance with the model developed in collaboration with stakeholders and presented to the General Assembly in December 2008, including a pay-for-improvement component. Proposed regulations at COMAR 10.09.10.11-1—.11-6, as submitted to be published in the *Maryland Register*, are attached to this transmittal.

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 to the limitations set forth by SB 101, facilities with less than 40 percent of their days of service provided to Medicaid residents are not included in the P4P program. Facilities that meet the following criteria during the 1-year period ending March 31, 2010 would also be excluded from P4P:

1. Any facility identified by the Centers for Medicare and Medicaid Services as a "special focus" facility.[1]
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.

The quality measures chosen for use in P4P are as follows:

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

Each facility will receive a composite score which will determine the facility's rank and subsequent amount of payment per Medicaid patient day. Under the current model, the highest scoring facilities representing 35 percent of the eligible days of care, receive a quality incentive payment. In addition, facilities' prior year's data will be rescored based upon the current P4P criteria and facilities that do not receive a P4P incentive payment this year, but whose scores have improved, are eligible for pay-for-improvement monies.

Each Medicaid-enrolled nursing facility will receive an enclosure with this transmittal indicating its eligibility for P4P or pay-for-improvement. Eligible providers will receive a score on each of the quality measures, its total score, its rank among eligible facilities, and the amount of payment for which it qualified. The highest scoring facilities, representing 35 percent of the eligible days of care, will receive quality incentive payments within a payment range of $.89 to $1.78 per Medicaid patient day. Pay-for-improvement amounts range from $.18 to $.36 per Medicaid patient day. These ranges will vary from year to year. Data will also be scored for facilities that are not eligible for P4P in order to provide performance feedback.

Providers shall have 30 days from the date of this transmittal to review and comment on performance data. If there are any errors in the data, all facilities will be rescored and revised scores will be distributed. A final 30-day review period will be allowed if the rescoring results in significant modifications. It is anticipated that providers will receive a lump-sum payment in October 2010 based on this year's results.

Questions regarding this transmittal may be directed to the Nursing Home Program at 410-767-1736.

Attachments

cc: Nursing Home Liaison Committee

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[1] http://www.cms.hhs.gov/certificationandcomplianc/downloads/sfflist.pdf

COMAR 10.09.10.11-1—.11-6 Nursing Facility Pay-for-Performance

.11-1 Pay-for-Performance—Eligibility.

In order to be eligible to receive funds through the pay-for-performance program under the provisions of Regulations .11-2—.11-6 of this chapter:

A. The provider shall:
(1) Be subject to quality assessment under COMAR 10.01.20;
(2) Have at least 40 percent of days of care during their most recent fiscal cost reporting period paid by Medicaid; and

B. During the 1 year period ending March 31 of the prior State fiscal year, the provider may not have been:
(1) Identified by the federal Centers for Medicare and Medicaid Services as a Special Focus Facility;
(2) Denied payment for new admissions by the Department; or
(3) Identified by the Department as delivering substandard quality of care.

.11-2 Pay-for-Performance—Quality Measures.

A. Providers shall receive a composite score based upon the following:
(1) Staffing Levels and Staff Stability shall comprise 40 percent of each facility's score;
(2) Maryland Health Care Commission Family Satisfaction Survey shall comprise 40 percent of each facility's score;
(3) Minimum Data Set Clinical Quality Indicators shall comprise 16 percent of each facility's score;
(4) Employment of Infection Control Professional Survey shall comprise 2 percent of each facility's score; and
(5) Staff Immunization Survey shall comprise 2 percent of each facility's score.

B. Staffing Levels.
(1) Each facility's average staffing level shall be determined from its most recent data reported in accordance with Regulation .11G(1) of this chapter. Total staff hours shall be divided by average daily census during the survey period in order to establish its average daily staffing.
(2) Each facility's average acuity shall be determined from claims for services provided by the facility during the one year period ending September 30 of the most recent prior State fiscal year. To establish expected staffing hours, each day of care and procedure is multiplied by the daily hours required under Regulation .25B of this chapter and divided by the total days of care during the same period.
(3) The result from §B(2) of this regulation shall be multiplied by 1.26555 in order to establish the facility's staffing goal.

(4) The facility's staffing level from §B(1) of this regulation shall be divided by the facility's staffing goal from §B(3) of this regulation in order to determine a score based on its percentage of the goal. A facility staffing exceeding its goal shall be scored at 100 percent.
(5) Providers shall receive 0-20 points based upon the scoring methodology described under Regulation .11-3 of this chapter.

C. Staff Stability.
(1) Staff stability is based upon dates of employment for nursing staff reported on the facility's most recent salary and hours survey in accordance with Regulation .11G(1) of this chapter.
(2) Staff stability shall be determined by the percentage of hours provided by staff employed by the facility for 2 years or longer at the time of the survey.
(3) Providers shall receive 0-20 points based upon the scoring methodology described under Regulation .11-3 of this chapter.

D. Family Satisfaction.
(1) Family satisfaction shall be determined based upon results from the facility's most recent Family Satisfaction Survey administered by the Maryland Health Care Commission.
(2) Providers shall receive 0-40 points based upon the scoring methodology described under Regulation .11-3 of this chapter, as follows:
(a) 0-20 points shall be based upon questions regarding general satisfaction; and
(b) 0-20 points shall be based upon scores in each of several categories, which are comprised of questions regarding specific aspects of care and environment in the nursing facility.

E. Minimum Data Set Clinical Quality Indicators.
(1) Providers shall receive scores based on the following quality indicators for long-stay residents from resident assessment data (from the Minimum Data Set published by the federal Centers for Medicare and Medicaid Services) for the three-month period ending December 31 of the most recent prior State fiscal year:
(a) Percent of High-Risk Residents Who Have Pressure Sores;
(b) Percent of Residents Who Were Physically Restrained;
(c) Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder;
(d) Percent of Residents with a Urinary Tract Infection;
(e) Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season; and
(f) Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination.
(2) Providers shall receive 0-2.67 points for each quality indicator based upon the scoring methodology described under Regulation .11-3 of this chapter.

F. Employment of Infection Control Professional.
(1) In accordance with state licensing regulations under COMAR 10.07.02.21, all Maryland nursing facilities are required to employ a trained Infection Control Professional (ICP). Scoring shall be based upon compliance with COMAR 10.07.02.21 as follows:
(a) Facilities not in compliance with COMAR 10.07.02.21 shall receive no points;
(b) A facility meeting the minimum requirement of COMAR 10.07.02.21 shall receive 1 point; or
(c) A facility shall receive 2 points if:
(i) In a facility with 200 or more beds, an ICP is dedicated 35 hours or more per week to infection control responsibilities; or
(ii) In a facility with fewer than 200 beds, an ICP is dedicated to infection control responsibilities 15 hours or more per week.
(2) Providers shall receive 0-2 points for this component. Data will be collected by the Department in April of each year.

G. Staff Immunizations.
(1) Providers shall receive a score based on the percentage of nursing facility staff (all staff classifications) that have been vaccinated against seasonal influenza.
(2) The benchmark for staff vaccinations is 80 percent.
(a) Nursing facilities that meet or exceed the benchmark of 80 percent for seasonal flu shall receive 2 points;
(b) Facilities with less than 80 percent may not receive points for this component.
(3) Providers shall receive 0 or 2 points for this component. Facilities shall submit data to the Department regarding all individuals employed or contracted by the facility during the period September through April 15.

.11-3 Pay-for-Performance—Scoring Methodology.

A. Facilities that are eligible for pay-for-performance under the provisions of Regulation .11-1 of this chapter shall receive a score for each quality measure described in Regulation .11-2 of this chapter. The highest ranked 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 would be received by any facility whose raw score is below the median by an amount equal to or greater than the difference between the highest points and the median points. All other facilities will receive points proportionate to where the score falls within the range between the highest and zero.

B. Points for each quality measure are summed and facilities will receive a composite score.

.11-4 Pay-for-Performance—Payment for Improvement.

A. In order to be eligible for improvement payment, a facility shall:
(1) Meet the eligibility criteria specified at Regulation .11-1 of this chapter;
(2) Be eligible and receive a composite score during the current year and the prior year; and
(3) Not be receiving a payment based upon its score as described under Regulation .11-6C of this chapter.

B. Facilities shall be ranked according to the greatest point increase compared with the prior year.

.11-5 Pay-for-Performance—Scoring Data Review.

A. The Department shall issue by transmittal scores for pay-for-performance quality measures under Regulation .11-2 of this chapter, on or about July 1 of each year, based upon data compiled during the prior fiscal year.

B. Facilities shall have 30 days from the date of the transmittal to review and comment on performance data.

C. If the Department determines that there are any errors in the data, all facilities shall be rescored and revised scores shall be distributed. A final 30-day review period shall be allowed if the rescoring results in significant modifications.

.11-6 Pay-for-Performance—Payment Distribution.

A. During the State fiscal year 2011, 0.2445 percent of the budget allocation for nursing facility services shall be distributed based upon pay-for-performance scores.

B. Beginning State fiscal year 2012, and each year thereafter, 0.5 percent of the budget allocation for nursing facility services shall be distributed based upon pay-for-performance scores.

C. 85 percent of the amount identified in §A or §B of this regulation shall be distributed to the highest scoring facilities, representing 35 percent of the eligible days of care, in accordance with the methodology described in Regulation .11-3 of this chapter.

D. Funds shall be distributed among the facilities identified in §C of this regulation, based upon their relative scores, weighted by total days of care, such that the highest scoring facility shall receive twice the amount per day as the lowest-scoring facility receiving payment.

E. 15 percent of the amount identified in §A or §B of this regulation shall be distributed to each facility for payment for improvement in accordance with Regulation .11-4 of this chapter.

F. Funds shall be distributed among the facilities included in §E of this regulation, based upon their relative point increase from the prior year, and weighted by total days of care, such that the facility with the greatest point increase shall receive twice the amount per day as the facility with the smallest point increase.

G. A facility shall receive a lump-sum payment based upon the per diem amount determined in accordance with §D or §F of this regulations, multiplied by its Medicaid days of care in its most recent cost report, not to exceed one year.