IDAHO DEPARTMENT OF
HEALTH & WELFARE

State of Idaho
Department of Health and Welfare

Nursing Facility

Quality Payment Program Guide

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1. Supplemental Payment History

Beginning in state fiscal year 2010, the state of Idaho implemented cost cutting measures in the nursing facility (NF) rate methodologies. The efficiency incentive add-on for indirect costs was removed, inflation from the cost reporting period to the rate year was removed, and the overall rate was subjected to a 2.7% reduction. As a result, the Department of Health and Welfare (Department) implemented an Upper Payment Limit (UPL) supplemental payment program to replace the lost funding from the rate reductions. The UPL program provides supplemental payments to NFs using a combination of provider assessments and intergovernmental transfers (IGT) to fund the state share of the supplemental payment. In the initial year of the UPL program, the payment was limited to cover the estimated losses providers incurred from the change in rate methodology. Later, the program was revised to pay providers the entire available UPL gap.

UPL supplemental payments are based on the difference between what Medicare would have paid and what Medicaid did pay for NF services provided to Medicaid residents. That difference, or gap, can be distributed to providers as a supplemental payment. Currently, the UPL program provides approximately $59 million dollars of supplemental payments to all providers with the exception of the state owned and operated facilities.

The Department currently contracts with two participating managed care organizations (MCOs) to administer a managed care program to dual-eligible beneficiaries. Enrollment in MCOs has increased over 30% since last year at the same time. Federal rules do not allow supplemental UPL payments on managed care days; therefore, the growing enrollment trend into MCOs will impact UPL payments that are based on traditional fee-for-service days. It is estimated that this reduction in fee-for-service days would reduce the supplemental payments by approximately $49 million.

Under federal regulations, states have the flexibility to implement supplemental payment systems that are based on quality. The Department has formed a work group with the Idaho Health Care Association, American Health Care Association, other providers, and the consulting firm of Myers and Stauffer to develop the Nursing Facility Quality Payment Program system based on quality. The Department is appreciative of the collaboration and input received from state and national nursing facility representatives for improving quality of care and life for our most frail and elderly participants. This input has been informative to deliberations on the best way to move forward. This document summarizes the work group decisions, methodologies, plan details, and timelines of the proposed system.

2. Quality Measures

The goal of this new payment structure is to link supplemental payments to the quality of care provided by NFs participating in the Medicaid program. Linking payments to quality of care is a primary goal of the Centers for Medicare & Medicaid Services (CMS) and the Department, and provides a strong financial incentive to NFs to improve the quality of care and lives of the residents they serve.

A. Quality of Care Measures

The Department and NF industry representatives have reached consensus on the following nine measures, which leverage existing and readily accessible data. These measures capture common clinical outcomes for long-stay residents and are reflective of the overall quality of the NF. These represent reasonable indicators of quality of care and will be used in Idaho's Nursing Facility Quality Payment Program. During initial discussions, the consensus was to utilize ten measures, but on October 1, 2019, CMS removed the measure to remove moderate to severe pain from their Five Star quality program. As a result, this measure was removed from the calculation of the total quality based score for the Idaho Quality Payment Program.

- *Eight Minimum Data Set (MDS) long-stay quality measures*.
  - These measures are derived from the Minimum Data Set (MDS) used by CMS in the Five Star quality rating program for NFs.
  - All NFs are required to submit data to a national MDS repository and CMS has made the data available to states to use in various rate-setting systems.
  - Data is calculated using a four-quarter average.
- *One PointRight® Long-Stay Hospitalization measure from the National Quality Forum endorsed measure about hospitalization rates.*
  - Data is calculated from the most recent data available. This measure is an MDS-based, risk adjusted measure of the rate of hospitalization of long-stay patients of NFs averaged across the year, weighted by the number of stays in each quarter.

Table 2.1 Long Stay Quality Measures Selected for NF Quality Measure Program

#	Measure	Data Source	Measure Source	Points Available [1]
1	Antipsychotic medication use	MDS	CMS NHC	20 to 100
2	Urinary tract infections	MDS	CMS NHC	20 to 100
3	Pressure ulcers	MDS	CMS NHC	20 to 100
4	Indwelling catheter	MDS	CMS NHC	20 to 100
5	Decline in late-loss ADLs	MDS	CMS NHC	20 to 100
6	Decline in mobility	MDS	CMS NHC	20 to 100
7	Physical restraints	MDS	CMS NHC	20 to 100
8	Falls with major injury	MDS	CMS NHC	20 to 100
9	Long stay hospitalization rate (Point Right Pro Long Stay)	MDS	AHCA [2]	20 to 100
Minimum Points Available				180
Maximum Points Available				900

[1] Points are calculated in increments of 20 (20, 40, 60, 80, 100) using the same methodology used by CMS for their 5 Star rating system.
[2] https://www.ahcancal.org/research_data/quality/Pages/Measure%20Downloads.aspx

3. Point Assignment Steps

The quality payment parameters are determined using provider scores for all nine quality measures. Scores for all providers will be arrayed and payment tiers will be calculated. Percentages are assigned to each payment tier in order to determine the portion of each provider's quality payments they are eligible to receive. Therefore, the payment tier that each provider falls into will be used to determine their quality payment. The payment percentages by tier are described in Section 4.

A. Base Year for Payment Tiers

Provider quality payments will be based on the payment tier their score falls within. The options discussed for the tier calculations were to either recalculate them annually or use a base period where the payment tiers will remain intact for several years. The work group concluded that a base period is preferable in order for the providers to track their progress over a five-year period.

The base period will be used to compile provider scores and to calculate payment tiers. The base year tiers will then be used to determine payments moving forward. Following is a high-level summary of the base year concepts:

- ***Base year*** – Quality scores captured for the most current data available as of 12/31/17.
- ***Tier groups*** – The 2017 quality scores will establish three payment tiers that will be applied until a rebase occurs.
- ***Years in use before a rebase is evaluated*** – The payment tiers will remain in place through the SFY 2025 payments and then will be reevaluated. Refer to Table 3.2.

Following is a summary of the steps that will be taken to calculate the base year tiers and point ranges:

Table 3.1 Base Year Payment Tier Calculation Steps

Step	Topic	Discussion and Tiers
1	Capture provider scores	Gather the scores using the data sources described in Table 2.1.
2	Data period	Scores available as of 12/31/17
3	Score tabulation	Sum the scores for all 9 measures to determine a total score for each provider
4	Calculate 2017 base year point ranges for the 3 Tiers	Using the array of all provider scores, calculate 3 Tiers as follows. Refer to Appendix A for detail calculations. Tier 1 720 – 900 points 75th Percentile Tier 2 620 – 700 points Minimum 100 Points below Tier 1 Tier 3 180 – 600 points All Points below Tier 2

B. Quality Score Cut Points

Point values assigned to each quality measure will remain unchanged until a rebase occurs. Refer to Appendix B and C for the point value range for each quality measure.

C. Anomalies in the Data

In the cases of data anomalies or missing data, the work group decided on the following methods:

i. Missing Quality Measure Scores

While most Idaho NFs have data for all nine of the measures, some do not. When quality measure data is missing, the work group decided to impute scores for each missing measure using the median score of all Idaho NFs.

ii. Providers with Special Care Units

For the quality measures identified below, providers expressed concern over the observed lower scores of NFs with Behavior Care Units (BCU) or those providing ventilator care.

- Antipsychotic use for long-stay residents
- ADLs decline

The providers asserted that these special units may tend to score lower simply due to the nature of the residents served. For the two quality measures listed above, the work group proposed the following solutions:

- Applicable only to providers with state designated units (currently BCU, and special care facilities under IDAPA 16.03.10.269.06.a) and those providing ventilator care.
- Allow the provider the higher of their own score or the statewide median score of the non-unit providers for each measure.

During the review period for SFY23, three facilities with BCU designation filed disputes due to the fact that the original program structure did not anticipate that the non-unit facilities would average below the state median. As a result of the dispute process and subsequent NFQPP stakeholder meeting, the program is being revised to apply the calculated statewide median for all providers in lieu of the statewide non-unit median, if it is a higher score.

Any facility that met the BCU qualification requirements as of the beginning of the rate period within the quality measurement year would be considered a BCU for the quality measures calculations. Rate periods have a July 1 start date.

iii. Quality Measure Treatment through COVID-19

During the COVID-19 pandemic, the majority of providers experienced a decrease in their total scores for the quality measures listed in Table 2.1. Upon review of detail of the decrease in scores, it was determined that two quality measures were the main contributing factors for the decreases. Those quality measures were Decline in Late-Loss ADLs and Decline in Mobility.

Decreases were expected in these areas because of the isolation protocols put into place in an effort to reduce the spread of the COVID-19 virus. In order to address the decrease in scores, the Department opted to increase each provider's total quality measure score by 40 points. The

increase of 40 points will be in effect for SFY 2022. Due to continued effects of COVID-19, the Department applied the 40 point increase for SFY 2023 as well.

When tiers are calculated for SFY 2024, the 40 points added to each provider's score will be excluded. This will allow tiers for that period to not be negatively impacted by the Department's decision to increase total quality scores by 40 points in SFY 2022 and SFY 2023.

iv. Quality Measure Treatment with Frozen Measures

On October 1, 2023, the quality measure scores measured by Centers for Medicare and Medicaid Services (CMS) were frozen for Decline in Late-Loss ADLs, Decline in Mobility on Unit, and High-Risk Residents with Pressure Ulcers. Additionally, the one PointRight measure has received minimal updates through the years. The Department notified providers in a nursing facility provider meeting on December 6, 2023 the measures would continue to be used and the most recent available data would determine the current year score for those measures.

D. Timeline After Base Year

The quality payment calculations are performed annually with a goal of sending payment notice letters every August. The steps identified in Sections A and B above will be applied each year when gathering the quality measures. Following is the timeline and data sources for the program:

Table 3.2 Data Sources and Base Year Timeline

UPL Paid in SFY	Medicaid Rates Paid	Medicaid Days from Provider FYE	QMs Based on the Four Quarter Average Ending	Base Year for Tiers	Payment Type [1]
6/30/19	7/1/17 – 6/30/18	2016	12/31/17	12/31/17	Shadow
6/30/20	7/1/18 – 6/30/19	2017	12/31/18	12/31/17	Shadow
6/30/21	7/1/19 – 6/30/20	2018[2]	12/31/19	12/31/17	Year 1
6/30/22	7/1/20 – 6/30/21	2019	12/31/20	12/31/17	Year 2
6/30/23	7/1/21 – 6/30/22	2020	12/31/21	12/31/17	Year 3
6/30/24	7/1/22 – 6/30/23	2021	12/31/22	12/31/17	Year 4
6/30/25	7/1/23 – 6/30/24	2022	12/31/23	12/31/17	Year 5
6/30/26	7/1/24 – 6/30/25	2023	12/31/24	Rebase	

[1] See Section 4E for description of shadow payments.
[2] Beginning this year, days will be a combination of Idaho Medicaid Managed Care and traditional Medicaid. All days will be captured for the available supplemental payment pool calculations.

4. Supplemental Payment and Provider Assessment Calculations

This section describes how payment tiers translate to payments. The Department will make the quality payments to providers once a year.

A. Determine the Quality Payment Pool

Historically, the supplemental payment pool has been determined as follows:

Step 1) Calculate what Medicare would have paid each provider using Medicare RUG rates

Step 2) Calculate what Medicaid did pay each provider

Step 3) Calculate the UPL gap as Step 1 – Step 2 * traditional Medicaid fee-for-service (FFS) patient days

Step 4) Sum the UPL gap by each ownership class (private, government, state-owned)

Step 5) Distribute the sum of the gap for each class to each provider based on their share of Medicaid days to the total Medicaid days in the class.

Step 6) The result in Step 5 is the funding pool available to each provider. Based on their quality score, they will be paid a percentage of their own pool and not a percentage of the entire pool for the class.

For the new quality measure system, a similar method will be used with the only exception being that instead of basing the gap calculation on only traditional Medicaid FFS days and payments, it will be based on traditional FFS days plus Idaho Medicaid managed care days and payments.

The calculation will provide a UPL gap for each payer (FFS and each MCO) to determine the pool of dollars to distribute by each payer. Idaho Medicaid will issue payments for traditional FFS days. For the MCOs payments, Idaho Medicaid will provide a lump sum payment to each MCO and will also identify the calculated payment the MCO will issue to each facility. The calculation for the MCO payments related to managed care days will follow the same parameters as listed above.

B. Payment Percentages

Once each provider's total available fund pool is determined, and their quality scores for the payment year have been tabulated, the following payment tier methodologies will be applied to their available pool:

Table 4.1 Percentage of Each Provider's Available Pool Paid by Tier Group

Payments Based on Change in QM Score From Prior Year			
Tier	Improved by 40 Points or More	No Change	Declined by 40 Points or More
1	100%	100%	100%
2	100%	100%	95%
3	100%	95%	90%

C. Undistributed Funds

Because each provider will be paid between 90% and 100% of their available pool of funds, there may be excess funds available to distribute. The excess funds will be summed by ownership class and every provider in that class will receive a share of the undistributed pool based on their percent of FFS and Idaho managed care days to total FFS and Idaho manged care days in their ownership class.

D. Provider Assessment

The provider assessment is currently calculated once a year, at the same time the quality payments are calculated. The assessment has historically been set at an amount to cover the state share of the supplemental payments paid to privately owned providers plus an administrative fee for Myers and Stauffer to prepare the calculations. The assessment methodology will remain unchanged.

Non-state government owned providers are exempt from the assessment and instead pay an IGT payment to the state to cover the state share of each provider's payment. During the 2018 legislative session, Idaho State Veteran's Home providers are now eligible to participate in the UPL payment program. These providers are state operated and are also exempt from the assessment. They will instead pay an IGT payment to the state to cover the state share of each provider's payment.

E. Shadow Payments

The current UPL payment system will continue through the payment made in SFY ending 6/30/20 because it relies on patient days. This will allow providers time to learn and adapt to the new system and begin working to improve their quality scores in the hopes of receiving 100% of their available fund pool in the future.

For the years leading up to the full implementation date, the work group decided that issuing shadow payment calculations would serve to remind providers to focus on quality care. In addition, the shadow payments will be in a format that will be educational to providers so they can learn the new system.

The shadow payment will be issued annually along with each provider's current UPL payment calculation. It will show the provider what they would have been paid had the new system been live.

Providers will be issued quarterly reports that show their most recent quality scores. There will not be a shadow payment attached to the quarterly reports as shadow payments only occur annually. However, the report will show their quality scores so they can be aware of their score throughout the year.

F. Calculated Tier and Percentage Payout

During the second quarter of the calendar year, each provider will receive a Quality Standing report along with the standard quarterly report. The Quality Standing report will include the provider's adjusted quality scores based on the four quarter average from the preceding calendar year, payment tier, and UPL payment percentage. Providers should review the Quality Standing

report to determine if they disagree with any of their scores. If a provider disagrees with their score, procedures outlined in Section G, Dispute Process, should be followed.

G. Dispute Process

The dispute process was created by the work group to address concerns that nursing facilities may not take individuals that have complex needs for fear those individuals may drive down quality scores. Any NF that believes the calculated quality scores do not reflect the actual quality care that was provided during the reported year is allowed to submit documentation to dispute their scores. NFs may only dispute the calculated quality scores as stated in the Quality Standing report issued in the second quarter following the end of the reporting year. The Dispute Process steps are as follows:

Step 1) Each NF receives quarterly reports with raw quality measure scores. Any NF with concern that their quality scores are not reflective of the actual care provided should begin the research to determine the cause of the quality scores and compile supporting documentation.

The burden of proof lies with the NF. The Department does not have the capability to compare one or more MDS assessments to another set of residents to determine the effect of changes in quality measure scores or to model the impact of one resident's score and how it affects the total facility score.

Step 2) After receiving the Quality Standing report, any NF wishing to dispute their quality scores must submit documentation supporting their position within 21 days from the send date as stated on the Quality Standing report. The submission of supporting documentation initiates the Dispute Process. Late submissions will not be accepted. Supporting documentation must be provided in an electronic format and transmitted via efax, email, or mail for encrypted data storage devices such as thumb drives. No paper documents will be accepted.

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Step 3) A review committee, as established by the work group, will consist of four (4) members. The review committee is charged with reviewing and evaluating the submitted disputes and determining the resolution to the disputes. Each stakeholder member of the review committee will be required to sign a confidentiality agreement as the documentation submitted by nursing facilities will most likely contain protected health information (PHI). Committee members are as follows:

- Robert Vande Merwe – Executive Director of the Idaho Health Care Association (IHCA)
- Chris Hansen – Director of Reimbursement, Ensign Facility Services, Inc.

- James Winfield – Director of Accounting at Cascadia Healthcare and IHCA Chair of the Skilled Nursing and Assisted Living Reimbursement Committee
- Susie Choules – Program Manager for the Bureau of Long Term Care, Division of Medicaid

In the event that a committee member has a conflict of interest with a facility that has submitted a dispute, the remaining members of the committee will appoint an alternate to participate. If an alternate member cannot be selected timely, the dispute review process may proceed with three of the four established members.

Step 4) Notification of the resolution will be provided by the review committee to the disputing NF, the work group, the Bureau of Financial Operations, and its contractor, Myers and Stauffer, no later than June 30 of the same year.

5. Appendices

A. **Revised 2017 Base Year Tiers**

B. **MDS Quality Measures 1-9 Quality Score Cut Point – Range for Point Values for Quality Measures**

C. **Long Stay Hospitalization Quality Measure 10 – Cut Points**

D. **NF Quality Payment Program at a Glance**

E. **2017 Base Year Tiers (Superseded)**