Nursing Facility Quality Payment Program Work Group

October 16, 2018

10:30am -11:30am

Agenda

Introductions

In-Person – *Nursing Facility Representatives* - James Winfield, Terri Roche, Robert Vande Merwe, Scott Burpee, Rick Holloway, *Medicaid* – Alex Childers-Scott, Angela Toomey (formally Simpson) and Will Gibson *Myers and Stauffer* – Tammy Martin, Darin Lloyd and Krista Stefani

Phone/WebEx – Jeff Moore, Sandra Whitley, Ken Hutchinson, Amy Seils

Added Information to Final Report

Changes were made based on the last meeting.

- Changed Tier 2 to reflect a 100-point range
- Long Stay Hospitalization Quality Measure 10 – cut points were added to Appendix C
- NFQPP role out was added
- Updated the Veteran's Home contribution to the Assessment Fund

Long Stay Hospitalization and Percentracnk.inc Function

Darin Lloyd from Myers and Stauffer provided clarification about the Percentrank.inc Function. This information is included as additional documents to the meeting minutes.

Nursing Facility Score Report

For clarification purposes, it was decided to remove the number of facilities falling within each tier. This would be particularly confusing as the number would not always be reflective of current nursing facilities as the numbers would be based from the previous year.

The number of facilities is included in Appendix A in the final report. This number will be updated as needed to accurately reflect the number of active nursing facilities participating in the NFQPP.

Dispute Process

The Division asked for ideas on the dispute process for nursing facilities that disagree with their quality payment. Some concern was raised for providers that take difficult participants and the effect difficult participants could have on a facility's quality measures. Concern was also raised that facilities will not take difficult participants due to the perceived or potential impact the participant could have the facility's quality measures. The most difficult issue is that providers will have to identify which patient MDS was used in the quality scores to show that those hard to place residents are driving down the quality scores. This will be very difficult to show. The Division verbalized understanding of these

concerns and confirmed that any access issues discovered as a result of the NFQPP would be addressed within the work group and any changes necessary to the NFQPP could be accomplished in this forum. The Division, also, confirmed that any concerns that a nursing facility's quality payment was not reflective of the quality of care provided would have the opportunity to dispute this. The dispute process will take place within the work group. The Division is asking the work group for recommendations for documentation requirements and timeline. If a provider's dispute goes on for too long, it would impact the quality payments to the whole state because this will impact the redistribution of unpaid funds.

The timeline discussion did decide that the facility would have 60 to 90 days to file a dispute after the final yearly quality measure letters are sent. If quality measures are published by CMS in January or February, Myers and Stauffer should be able to mail the measures around the beginning of March. This would allow providers to file disputes immediately after to give the work group time to make a determination on the dispute by the end of May. This will allow time for all disputes to be resolved before supplemental payment letters are sent in August. The work group agreed that there should be a hearing committee, consisting of work group members and the Division. Consensus leaned towards having documentation from the nursing facility sent to the committee prior to an in-person hearing.

No formal decisions have been made concerning the dispute process at this time. In the next meeting, the work group hopes to gain better clarity as to requirements from a nursing facility wanting to dispute their quality payment.

*Myers and Stauffer will provide information to the work group at the next meeting when nursing facilities can receive their final quality measure report, indicating total percentage of payment to be received. It was discussed this could be the beginning of March but could not be certain of that time frame without further research. The dollar amount of the payment won't be able to be determined until August. However, providers will know their adjusted quality scores and percent payment in March.

Behavioral Care Units (BCU)

Adjusted Median Scores

The work group decided newly approved BCUs will have to be an approved BCU for 6 months of the year to be eligible for the 'state median' score for three of the 10 quality measures. If a facility was approved as a BCU at the beginning of the Rate Period (7/1) within the quality measurement year, then the facility would be considered as a BCU for the Quality Measures calculations.

The workgroup requested a current listing of approved BCU providers be posted regularly on the DHW website for discharge planning.

Annual Reviews – Rule Language

The Division requested feedback for IDAPA 16.03.10.266, specifically annual renewal for BCUs. The Division offered amending the current rule to strengthen the ability of the Division to further review compliance of BCUs to the initial requirements when applying to become a BCU. The work group was uncertain about a rule change and offered a yearly signed commitment for reapply facilities indicating the facility continues to follow all requirements to operate as a BCU.

Open Discussion

Angela Toomey (formally Simpson), brought up the issue of providers making their annual assessment fund contribution in payment arrangements versus a lump sum. This will be discussed in further detail at the next meeting.