Quality Measure Initiative Effectiveness

(FY2020 Appropriation Bill – Public Act 67 of 2019)

March 1, 2020

Sec. 1646. *(1) From the funds appropriated in part 1 for long-term care services, the department shall continue to administer a nursing facility quality measure initiative program. The initiative shall be financed through the quality assurance assessment for nursing homes and hospital long-term care units, and the funds shall be distributed according to the following criteria:*

(a) The department shall award more dollars to nursing facilities that have a higher CMS 5-star quality measure domain rating, then adjusted to account for both positive and negative aspects of a patient satisfaction survey.

(b) A nursing facility with a CMS 5-star quality measure domain star rating of 1 or 2 must file an action plan with the department describing how it intends to use funds appropriated under this section to increase quality outcomes before funding shall be released.

(c) The total incentive dollars must reflect the following Medicaid utilization scale:

(i) For nursing facilities with a Medicaid participation rate of above 63%, the facility shall receive 100% of the incentive payment.

(ii) For nursing facilities with a Medicaid participation rate between 50% and 63%, the facility shall receive 75% of the incentive payment.

(iii) For nursing facilities with a Medicaid participation rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid participation rate.

(iv) For nursing facilities not enrolled in Medicaid, the facility shall not receive an incentive payment.

(d) Facilities designated as special focus facilities are not eligible for any payment under this section.

(e) Number of licensed beds.

(2) The department and nursing facility representatives shall evaluate the quality measure incentive program's effectiveness on quality, measured by the change in the CMS 5-star quality measure domain rating since the implementation of quality measure incentive program. By March 1 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the senate and house policy offices on the findings of the evaluation.

MDHHS

Michigan Department of Health & Human Services

Section 1646(2) PA 67 of 2019

Background

The Health Care Association of Michigan (HCAM) proposed the Quality Measure Initiative (QMI) in December of 2016. The initiative was authorized in Section 1646 of PA 107. The Michigan Department of Health and Human Services (MDHHS) issued MSA Policy Bulletin MSA 17-28 in August of 2017, and the policy regarding QMI became effective October 1, 2017.

Purpose

The nursing facility QMI payments provide supplemental funds to invest in quality improvement efforts.

QMI payments to nursing facilities are based on their Quality of Resident Care Measure domain rating on the Nursing Home Compare (NHC) website, along with a resident satisfaction survey factor. Additional provider tax payments are used to generate approximately $70 million in funding annually.

The Centers for Medicare and Medicaid Services (CMS) publishes the 5-Star Ratings as a resource for families seeking information on nursing facility's performance. The measures are: Health Inspections, Staffing Levels, Quality of Resident Care Measures, and Overall Rating. Each measure is rated on a scale of 1-5 stars, with 5 stars being the best. The QMI payments are only based upon the Quality of Resident Care Measures, which are derived from the Minimum Data Set resident assessments, completed by nursing facility nurses. The measures include conditions such as the percent of residents who are physically restrained, have symptoms of depression, use of antipsychotic medications, have falls resulting in major injuries, have pressure ulcers, etc.

Eligibility

To be eligible to receive a QMI payment, a provider must meet the following conditions:

- The provider must be a Class I or Class III nursing facility. Most facilities are Class I nursing facilities which are proprietary or nonprofit nursing facilities that do not fall under any other Class definitions. Class III nursing facilities are proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities.
- The provider must have a 1, 2, 3, 4 or 5-Star Quality of Resident Care Measure on the NHC website.
- The provider must be a Medicaid-certified nursing facility.
- The provider must not be designated as a Special Focus Facility (SFF) by the CMS. SFFs receive more frequent surveys due to their record of high number of survey citations. Michigan is required to identify 2 SFFs each year.
- If the provider has an average Quality of Resident Care Measure below 2.5 stars, they must submit a Corrective Action Plan to the Long Term Care Policy Section of MDHHS.

The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period.

Distribution Method

Payments to individual nursing facilities is determined by: (1) their Quality of Resident Care Measure; (2) Medicaid utilization rate; (3) number of licensed beds; and (4) use of a resident satisfaction survey.

1. Quality of Resident Care Measure

The individual nursing home's Quality of Resident Care Measure portion of their QMI payment is calculated for the first six months of the fiscal year. Fiscal Year (FY) 2020's payment tiers per star is listed below:

Payment tier for FY2020:

Five-Star Payment	$1,201.84 per licensed bed
Four-Star payment	$1,001.38 per licensed bed
Three-Star payment	$800.92 per licensed bed
Two-Star payment	$600.46 per licensed bed
One-Star Payment	$400.00 per licensed bed

2. Medicaid Utilization Rate and 3. Number of Licensed Beds

The adjusted QMI amount is multiplied by the number of licensed nursing facility beds licensed by the Department of Licensing and Regulatory Affairs to determine the QMI payment for the year.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale is applied as follows:

- Nursing facilities with a Medicaid utilization rate of above 63%, the facility receives 100% of the QMI payment.
- Nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility receives 75% of the QMI payment.
- Nursing facilities with a Medicaid utilization rate of less than 50%, the facility receives a payment proportionate to their Medicaid utilization rate.

4. Resident Satisfaction Survey Data

If a nursing facility submits its resident satisfaction survey data, it receives 100% of the QMI payment. If the nursing facility does not submit its resident satisfaction survey data, it receives 85% of the QMI payment.

Corrective Action Plans

Providers with a Quality of Resident Care Measure below 2.5 stars must file a QMI Corrective Action Plan with MDHHS to be eligible for QMI payments. The Corrective Action Plan must provide details on how the provider intends to use QMI funds to increase quality outcomes. If a nursing facility fails to provide a Corrective Action Plan, they are ineligible to receive a QMI payment for the State fiscal year.

Six months later the MDHHS requests an Action Plan Status Report. This follow-up to the Corrective Action Plan is voluntary for nursing facilities and does not impact their QMI payments.

Data

Table 1, Rows 1-3 shows the number of nursing facilities with Quality of Resident Care Measures that increased, decreased, or stayed the same. This data is based upon the first and fourth quarters of the first year of the QMI arrangement, and the first and fourth quarters of the second year of the QMI arrangement.

Table 1, Row 4 shows the number of nursing facilities that submitted the required Customer Satisfaction Survey.

Table 1, Rows 5-8 shows the responses to the requirement for nursing facilities with an average Quality of Resident Care Measure of less than 2.5 to submit a Corrective Action Plan for the first and second year of the QMI arrangement.

Table 1

		First Year of the QMI Arrangement		Second Year of the QMI Arrangement
1.	Increased Quality of Resident Care Measure between First Quarter and Fourth Quarter	132		71
2.	Decreased Quality of Resident Care Measure between First Quarter and Fourth Quarter	63		185
3.	No Change in Quality of Resident Care Measure between First Quarter and Fourth Quarter	246		182
4.	Submitted Customer Satisfaction Surveys	405		342
5.	Required a Corrective Action Plan	50		35
6.	Submitted a Corrective Action Plan	38		29
7.	Required a Corrective Action Plan for Two Consecutive Years	N/A (the first year)		10
8.	Submitted an Action Plan Status Report	11		N/A (Not due until mid-March, 2020)

Conclusion

Table 1 suggests that a large number of nursing facilities had a decrease in their Quality of Resident Care Measure in Year 2 compared to Year 1. The number of nursing facilities that had an increase in their Quality of Resident Care Measure was less in Year 2 compared to Year 1. In addition, fewer nursing facilities submitted a Customer Satisfaction Survey in Year 2 than in Year 1, and fewer nursing facilities were required to submit Corrective Action Plans in Year 2 compared to Year 1. It is not possible to draw conclusions about the efficiency of the QMI from current data because other variables affect the Quality of Resident Care Measures.