Testimony by Director Greg Moody
Governor's Office of Health Transformation
Nursing Facility Quality Measures

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Chairman Amstutz, Ranking Minority Member Sykes, and members of the House Finance Committee, my name is Greg Moody and I am the director of the Governor's Office of Health Transformation. Thank you for this opportunity to testify.

The State of Ohio Operating Budget enacted in June (House Bill 153) increased Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average rate in state fiscal year (SFY) 2011 to 9.7 percent in SFY 2013. It also created a subcommittee under the Unified Long-Term Care System Advisory Workgroup to identify accountability measures to be used in awarding points for the quality incentive payments and the methodology for calculating the quality incentive payments beginning on July 1, 2012.

Participants

I want to start by thanking the members of the subcommittee, which included AARP, Benjamin Rose Institute on Aging, Scripps Gerontology Center, State of Ohio Long-Term Care Ombudsman, Academy of Senior Health Sciences, LeadingAge Ohio, Ohio Health Care Association, and the Ohio Departments of Aging, Health, and Medicaid. The subcommittee also included four legislators, Representatives Sears and Antonio along with Senators Burke and Cafaro. We began meeting almost immediately after HB 153 was enacted in June, seven different times for a total of over 20 hours of discussion.

Process

All of the subcommittee members arrived with their own ideas about quality and what a measurement framework should be, and those first thoughts represented a wide range. But we committed ourselves to a process that helped sort out and prioritize our individual interests. For example, early in the process we agreed that each measure needs to be resident focused – that's our guiding principal – but also objective and easy to validate, evidence based, advantageous to residents and operators, easy to collect and low cost to implement, and something a nursing facility can act to improve. I'm very pleased that every measure you are considering today meets all of those tests.

After the subcommittee (1) identified guiding principles for choosing quality measures, we then (2) identified and reviewed existing measurement frameworks, (3) selected specific accountability measures consistent with the guiding principles, (4) developed the methodology for calculating quality incentive payments and a bonus system to redistribute

any unspent payments, (5) identified technical assistance to assist nursing facilities in achieving full quality payments, (6) determined a process for ongoing quality improvement and (7) reported our recommendations.

The subcommittee communicated its recommendations in a September 1, 2011 report to the Ohio General Assembly. We met with the Speaker's staff on September 23 to stress the importance of moving forward with legislative language. I want to thank you, Mr. Chairman, and Representative Sears for your leadership and quick action. The two bills you are considering in this committee today would implement the subcommittee's recommendations and create the mechanism to allocate $295 million in quality incentive payments to nursing facilities in SFY 2013. The House and Senate bills are almost identical, with the House version adding a provision requiring facilities to meet one of the clinical quality measures to qualify for any "bonus" payments.

In order to provide sufficient time for nursing facilities to prepare for this new methodology and for the administration to draft rules to implement this legislation, we urge the legislature to pass legislation before the end of this calendar year.

Accountability Measures

The subcommittee identified 20 accountability measures organized into five areas of priority: (1) overall performance on an existing quality measurement framework, (2) resident choice, (3) clinical performance, (4) environmental characteristics, and (5) staffing. For each measure, the subcommittee provided a definition, method of calculation, source of data, and the threshold a facility must meet to earn a point for the purposes of determining the amount of the facility's quality incentive payment.

My testimony includes a one-page summary of the subcommittee's proposed measures compared to the current framework. For example, there are 8 quality measures today and we propose 20. The current measures are facility-oriented, describing things like occupancy rate, acuity, and Medicaid utilization compared to other facilities. We propose moving to more person-centered measures, related to resident choice, clinical quality, and aspects of staffing that matter most to residents, like low turnover.

We also propose changing how quality points are calculated. Today, most points are awarded to facilities that are "above average," which automatically creates winners and losers *even if everyone shows improvement*. Instead, we set specific targets so any facility that improves quality and meets the threshold gets the point. Currently about half of the facilities can meet our proposed thresholds (same as today) but now there is an incentive for the other half to improve and get the point.

Payment Methodology

The subcommittee also developed a method for calculating quality incentive payments and a bonus system to redistribute any unspent payments beginning July 1, 2012. The proposed payment methodology assigns one point for each performance measure threshold a facility meets. A facility is required to get 5 points to receive the full quality payment of $16.44. Facilities with less than 5 points will receive one-fifth of the full quality payment per point. If some facilities do not achieve 5 points and funds are left at the end of the fiscal year, that residual amount will be distributed to facilities that earn more than 5 points, based on each facility's Medicaid bed days and total points.

The quality incentive payment enacted in HB 153 is very different from what we have today. The current payment system adds a small $3.03 quality payment on top of the base rate, which means even the worst performers are guaranteed 100% of their base rate. The new system puts $16.44 of each facilities base rate at risk, which means any facility that does not achieve 5 quality points will receive a rate reduction. What we are saying is that quality is not an add-on, but a basic expectation of how we do business.

Ongoing Quality Improvement

Finally, the subcommittee recognized the importance of ongoing quality improvement in Ohio's nursing homes. House Bill 153 created additional opportunities to connect person-centered care and health outcomes to reimbursement. These initiatives include creating a single point of coordination for people who are eligible for both Medicaid and Medicare, a streamlined Medicaid home- and community-based services waiver, and health homes for people with chronic conditions. The Office of Health Transformation will continue to work with all interested parties and keep you apprised of our progress through the Joint Legislative Committee for Unified Long-Term Services and Support.

Mr. Chairman, this is an opportunity to adopt innovative, new nursing facility accountability measures and financial incentives to improve care for residents. I want to conclude my remarks by again thanking the subcommittee, particularly Representative Sears. It is not easy getting consensus on quality, but the members of the subcommittee stuck with it through many long hours of debate, holding to their principles but also giving ground as appropriate until we arrived at a workable package. I recommend your adoption of these recommendations so that work may begin at the nursing facilities to improve their performance on the measures that matter most to residents.

Thank you.

Ohio Medicaid Nursing Facility Quality Measures and Incentive Payments

Current Framework	Proposed Subcommittee Framework
8 measures	20 measures
Facility-oriented measures	Person-centered measures
Points awarded "above average"	Points awarded for meeting set targets
Half "lose" even if everyone improves	Everyone can improve and get points
8 points required for full payment	5 points required for full payment
$3.03 added on top of the base rate	$16.44 built into the base rate
1.7% of the facility payment on average	9.7% of the facility payment on average
$54.6 million total in SFY 2012	$294.6 million total in SFY 2013
All funds distributed	Unspent funds redistributed as a bonus
In effect until June 30, 2012	In effect beginning July 1, 2012
Framework measure 1. Resident/family satisfaction above state avg. 2. No health deficiencies on most recent survey 3. No deficiencies with severity greater than "E" ***Resident Choice*** None ***Clinical Quality*** None ***Environment (facility-focused)*** 4. Occupancy rate above statewide average 5. Case-mix score above statewide average 6. Medicaid utilization above statewide average ***Staffing*** 7. Nursing hours above statewide average 8. Employee retention above peer group average	***Framework measure*** 1. Resident/family satisfaction score is at least 86 2. Facility participates in "Advancing Excellence" 3. No deficiencies with severity greater than "F" ***Resident Choice*** 4. Residents have dining choices 5. Residents bathe/shower when they choose 6. Residents go to bed/get up when they choose 7. Residents involved in care planning ***Clinical Quality*** 8. Residents not in severe pain (% TBD) 9. Residents without pressure ulcers (% TBD) 10. Residents not physically restrained (% TBD) 11. Residents without urinary infection (% TBD) 12. Facility tracks resident admissions to hospitals ***Environment (resident-focused)*** 13. At least 50% of Medicaid beds in private rooms 14. Facility has accessible bathrooms 15. Overhead paging limited to emergencies 16. Residents can personalize their rooms ***Staffing*** 17. Consistent assignment of nurse aides 18. Staff retention rate of at least 75% 19. Nurse aide turnover is not higher than 65% 20. Nurse aides attend resident care conferences