

HUMAN SERVICES DEPARTMENT [441]

Notice of Intended Action

Pursuant to the authority of Iowa Code 249A.4 and 2009 Iowa Acts, House File 811, section 33, the Department of Human Services proposes to amend Chapter 81, “Nursing Facilities,” Iowa Administrative Code.

The proposed amendments would:

- Implement a Medicaid nursing facility “pay for performance” program in place of the nursing facility accountability measures.
- Make technical changes to reflect the current organizational structure and processes of the Iowa Medicaid Enterprise, including the elimination of the reconsideration of a level-of-care determination before the determination can be appealed.

In accordance with legislative direction in 2008 Iowa Acts, Chapter 1187, section 33, the Department convened a workgroup to develop recommendations to redesign the nursing facility accountability measures program. The legislation required the workgroup to submit its recommendations for the redesign. As a result of the workgroup recommendations, 2009 Iowa Acts, House File 811, section 33, directs the Department to implement changes to the accountability measures program and the nursing facility reimbursement methodology effective July 1, 2009. The following changes are proposed in accordance with the legislation:

New benchmarks have been developed in four domains: quality of life, quality of care, access, and efficiency. Possible scores in each domain are: quality of life, 25 points; quality of

care, 59 points; access, 8 points; and efficiency, 8 points; for a potential total of 100 points. A facility must receive at least 51 points to qualify for any additional reimbursement. Add-on payments are graduated depending on the facility's performance score, as follows:

- A score of 51-60 points qualifies for an add-on of 1 percent of the direct care plus nondirect care cost component patient-day-weighted medians
- A score of 61-70 points qualifies for an add-on of 2 percent of the direct care plus nondirect care cost component patient-day-weighted medians.
- A score of 71-80 points qualifies for an add-on of 3 percent of the direct care plus nondirect care cost component patient-day-weighted medians.
- A score of 81-90 points qualifies for an add-on of 4 percent of the direct care plus nondirect care cost component patient-day-weighted medians.
- A score of 91-100 points qualifies for an add-on of 5 percent of the direct care plus nondirect care cost component patient-day-weighted medians.

A facility will forfeit all eligibility for pay-for-performance payments if during the payment period the nursing facility is cited for a deficiency rated at severity level of H or higher by the Department of Inspections and Appeals. A facility's payment add-on shall be reduced by 25 percent for each citation received during the year for a deficiency rated at severity level of G and shall be eliminated if the facility fails to cure the deficiency within the time allowed by the Department of Inspections and Appeals. No add-on shall be paid for any month when the Centers for Medicare and Medicaid Services has suspended the facility's admissions.

Facilities shall be required to post their results on the performance measures and the amount of add-on payments they receive. Facilities are required to use these payments to

support direct care staff through increased wages, enhanced benefits, and expanded training opportunities and to publish an accounting of how they used the funds.

These amendments do not provide for waivers in specified situations because the Department holds that all nursing facilities should be subject to the same pay-for-performance measures and scoring to determine add-on payments as a matter of fairness.

Any interested person may make written comments on the proposed amendments on or before November 10, 2009. Comments should be directed to Mary Ellen Imlau, Bureau of Policy Analysis and Appeals, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

These amendments are intended to implement Iowa Code section 249A.4 and 2009 Iowa Acts, House File 811, section 33.

The following amendments are proposed.

ITEM 1. Rescind the definition of “Iowa Foundation for Medical Care (IFMC)” in rule **441—81.1(249A)**.

ITEM 2. Rescind paragraphs **81.3(1)“a”** to **“d.”**

ITEM 3. Amend subrule **81.3(1)**, introductory paragraph, as follows:

81.3(1) Need for nursing facility care. Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. ~~Initial decisions~~ Decisions on level of care shall be made for the department by the ~~Iowa Foundation for Medical Care (IFMC)~~ Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. ~~After notice of an adverse decision by IFMC, the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician, or the nursing facility may request reconsideration by IFMC by sending a letter requesting a review to IFMC not more than 60 days after the date of the notice of adverse decision.~~ ~~On initial and reconsideration decisions, IFMC~~ The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. Adverse decisions by ~~IFMC on reconsiderations~~ the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

ITEM 4. Amend subrule **81.3(3)** as follows:

81.3(3) Screening. All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the ~~Iowa Foundation for Medical Care~~ IME medical services unit to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

a. Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health, ~~mental retardation and developmental disabilities~~ disability services.

b. Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the

division of mental health, ~~mental retardation and developmental disabilities~~ disability services that the person's treatment needs will be or are being met.

ITEM 5. Rescind paragraph **81.6(16)“g”** and adopt the following **new** paragraph in lieu thereof:

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities effective July 1, 2009, as provided in this paragraph. The pay-for-performance program provides additional reimbursement based upon a nursing facility's achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of the state fiscal year (which is referred to in this paragraph as the “payment period”).

(1) Scope. Additional reimbursement for the nursing facility-pay-for performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident's quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical

nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility-pay-for performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct-care staff that are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter July through March of payment period	2 points	Self-certification

Standard	Measurement Period	Value	Source
<p>Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.</p>	<p>For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period</p>	<p>1 point</p>	<p>Self-certification</p>
<p>Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower, and on which days and at what times the bath or shower will be taken.</p>	<p>For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period</p>	<p>1 point</p>	<p>Self-certification</p>
<p>Consistent Staffing: The facility has the same staff work with the same residents at least 70% of the time.</p>	<p>For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period</p>	<p>3 points</p>	<p>Self-certification</p>
<p>National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.</p>	<p>For SFY 2010, 10/1/09 to 6/30/10; thereafter payment period</p>	<p>13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.</p>	<p>Self-certification</p>

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey:</p> <p>The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	<p>For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter survey completed between October 1 and March 31 of the payment period</p>	<p>5 points</p>	<p>470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results.</p>
<p>Long-Term Care Ombudsman:</p> <p>The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman</p>	<p>Calendar year ending December 31 of the payment period.</p>	<p>5 points</p>	<p>LTC ombudsman list of facilities meeting the standard</p>

Standard	Measurement Period	Value	Source
<p>Resident Advocate Committees: The facility has an active resident advocate committee and submits meeting minutes to the LTC ombudsman at least quarterly. The minutes contain comments from residents (positive and negative). Minutes address how the facility worked to resolve any negative comments.</p>	<p>Calendar year ending December 31 of the payment period</p>	<p>2 points</p>	<p>LTC ombudsman list of facilities meeting the standard</p>

(6) Domain 2: Quality of care.

Standard	Period Measured	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey:</p> <p>The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR, Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure.</p> <p>Surveys are considered complete when all appeal rights have been exhausted.</p>	<p>Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations</p>	<p>10 points</p>	<p>DIA list of facilities meeting the standard</p>

Standard	Period Measured	Value	Source
<p>Regulatory Compliance with Survey:</p> <p>No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	<p>Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations</p>	<p>5 points</p> <p>NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.</p>	<p>DIA list of facilities meeting the standard</p>
<p>Subcategory: Staffing</p>			
<p>Nursing Hours Provided:</p> <p>The facility's per-resident-day nursing hours are at or above one-half a standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	<p>Facility fiscal year ending on or before December 31 of the payment period</p>	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation.</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus 1 standard deviation.</p>	<p>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.</p>

Standard	Period Measured	Value	Source
<p>Employee Turnover:</p> <p>The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	<p>Facility fiscal year ending on or before December 31 of the payment period</p>	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%.</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%.</p>	<p>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</p>
<p>Staff Education, Training and Development:</p> <p>The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	<p>Calendar year ending December 31 of the payment period</p>	<p>5 points</p>	<p>Self-certification</p>

Standard	Period Measured	Value	Source
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	<p>For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter survey completed between October 1 and March 31 of the payment period</p>	<p>5 points</p>	<p>470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results.</p>

Standard	Period Measured	Value	Source
Subcategory: Nationally Reported Quality Measures			
<p>High Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures</p>	<p>12-month period ending September 30 of the payment period</p>	<p>3 points if ½ to 1 standard deviation below the mean percentage of occurrences. 5 points if 1 standard deviation or more below the mean percentage of occurrences.</p>	<p>IME medical services unit report based on MDS data as reported by CMS</p>
<p>Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.</p>	<p>12-month period ending September 30 of the payment period</p>	<p>5 points</p>	<p>IME medical services unit report based on MDS data as reported by CMS</p>

Standard	Period Measured	Value	Source
<p>Chronic Care Pain:</p> <p>The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures</p>	<p>12-month period ending September 30 of the payment period</p>	<p>3 points if ½ to 1 standard deviation below the mean rate of occurrences.</p> <p>5 points if 1 standard deviation or more below the mean rate of occurrences.</p>	<p>IME medical services unit report based on MDS data as reported by CMS</p>
<p>High Achievement of Nationally Reported Quality Measures:</p> <p>The facility received at least 9 points from a combination of the measures listed in this subcategory.</p>	<p>12-month period ending September 30 of the payment period.</p>	<p>2 points if the facility receives 9-12 points in the subcategory of nationally reported quality measures.</p> <p>4 points if the facility receives 13-15 points in this subcategory.</p>	<p>IME medical services unit report based on MDS data as reported by CMS</p>

(7) Domain 3: Access.

Standard	Period Measured	Value	Source
<p>Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).</p>	<p>Status on December 31 of the payment period.</p>	<p>4 points</p>	<p>DIA list of facilities meeting the standard</p>
<p>High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.</p>	<p>Facility fiscal year ending on or before December 31 of the payment period</p>	<p>3 points if Medicaid utilization is more than the median plus 10%. 4 points if Medicaid utilization is more than the median plus 20%.</p>	<p>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</p>

(8) Domain 4: Efficiency.

Standard	Period Measured	Value	Source
<p>High Occupancy Rate: The facility has an occupancy rate at or above 95%. “Occupancy rate” is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.</p>	<p>Facility fiscal year ending on or before December 31 of the payment period</p>	<p>4 points</p>	<p>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</p>
<p>Low Administrative Costs: The facility’s percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.</p>	<p>Facility fiscal year ending on or before December 31 of the payment period</p>	<p>3 points if administrative costs percentage is less than the mean less one-half standard deviation. 4 points if administrative costs percentage is less than the mean less 1 standard deviation.</p>	<p>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</p>

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted

by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81– 90 points	4 percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91–100 points	5 percent of the direct care plus non-direct care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March

1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement for accountability measures pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The payment add-on shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's payment add-on shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the payment add-on shall be forfeited and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period (state fiscal year).

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to 81.6(16)“g”; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the Department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

ITEM 6. Amend rule 441--81.7(249A) as follows:

441—81.7(249A) Continued review. The ~~Iowa Foundation for Medical Care~~ IME medical services unit shall review Medicaid recipients' members' need of continued care in nursing facilities, pursuant to the standards and subject to the ~~reconsideration and appeals processes~~

process in subrule 81.3(1).

ITEM 7. Amend subparagraph **81.13(9)“F”(1)** as follows:

(1) A nursing facility shall not admit a new resident with mental illness or mental retardation unless the division of mental health, ~~mental retardation and developmental disabilities~~ disability services has approved the admission, based on an independent physical and mental health evaluation. This evaluation shall be reviewed by the ~~Iowa Foundation for Medical Care~~ prior to IME medical services unit before admission to determine whether the individual requires the level of services provided by the facility because of the physical and mental condition of the individual. If the individual requires nursing facility level of services, the individual shall receive specialized services for mental illness or mental retardation.