1199SEIU UHWE Comments on Navigant's Draft Model at AHCA Public Meeting
November 17, 2016

Although the Union does not oppose PPS as a method for Medicaid reimbursement, we reject the current Navigant models as presented on November 17th. As Navigant's models are currently designed, they incentivize a race to the bottom alongside windfalls for certain providers with no requirement that new money be spent on bedside care. Similarly, as the quality measures are currently designed, they fail to focus on critical factors, in particular drastically under rewarding the hours of direct care needed to ensure quality of life for nursing home residents. The consequences of the current models, intended or not, will be to undermine quality of care where it exists and unjustly enrich the lowest-performing operators in the industry.

1199SEIU Comments and Recommendations

- Staffing should continue to be reimbursed based on a facilities' actual costs, rather than on a statewide standardized price. Staffing is the single most important factor in quality of care, and it is a mistake to treat labor costs as any other commodity. The current Medicaid reimbursement system provides willing providers with the resources they need to improve staffing and working conditions for caregivers, subject to reasonable limits. The proposed models level out reimbursements for care cost centers, and will limit the ability of providers to improve their staffing standards in the future. This tradeoff is unnecessary; there is nothing inconsistent between a cost-based labor component and a PPS system.

- The current payment models proposed by Navigant will be disruptive to the industry. Many facilities will see their payments dramatically decreased; this will jeopardize their ability to provide quality care and remain solvent. Currently low-cost providers will see unearned increases in their rates with no accountability or requirements to spend those additional resources on the number or quality of their staff. Not only does the current Navigant model not deal with the issues addressed above, it fails at even attempting to mitigate industry wide disruption and patient care impacts:

    - Changes to facility reimbursements should be phased in over a period of years, with each facilities' increase (or decrease) limited each year to a percentage, until the plan is fully implemented.
    - Facilities whose non-property costs are below the median should be required to spend the additional revenue they receive in the direct and indirect care components. Facilities who fail to do so should be forced to repay the excess reimbursements to the State.

- 1199SEIU supports both the 7% quality pool and the 30th percentile threshold for receipt of the quality reimbursements.

- We oppose the dilution of the direct care staffing quality component in the November 17th models. We support the staffing component as presented in the October 26th models, which provide 6 points for Nurses, CNAs, activity and social work as a single category. Separating out Social Work/Activities as a separate category from nursing and dividing the points in half gives too little weight to direct care staff (nurses and CNAs) and far too much to important, but secondary, activities.

- We continue to oppose quality measures on secondary or derivative measures, like Florida Gold Seal and CMS 5 Star awards. The November model compounded this error, in our view, by extending quality points to other certifications like JCAHO and the Health Care Association National Quality Award.