1199SEIU UHWE Comments on Navigant's Draft Model at AHCA Public Meeting
September 22, 2016

Response to Navigant's Initial Findings and Proposals

1199SEIU United Healthcare Workers East ("1199SEIU") appreciates the continued dialogue with stakeholders in Florida as we explore new prospective payment systems for nursing home reimbursement across the state. 1199SEIU applauds the shift toward reimbursing quality. Caring for our residents and our communities is the foundation of our work and we are excited to pioneer new systems that promote - and provide - the highest quality of care.

Cost Based Reimbursement Underscores Critical Role of Direct Care

In an effort to assist nursing homes in reaching better quality outcomes the new prospective payment system should continue to reimburse direct labor costs under a cost based methodology. Moving toward a prospective payment system is not incompatible with a cost based reimbursement methodology. Rather than engaging in a retrospective reconciliation, reimbursement should be prospectively calculated based on a facility's costs, and rebased annually. Such a cost based prospective model would avert the incentives for facilities to compete over low wages and staffing levels inherent in a price based reimbursement. Rather than focusing on quality, such a competition puts the brunt of the changes on the direct care workforce that provides the daily care for all nursing home residents in the state.

Price Based Reimbursement Inappropriately Incentivizes Facilities to Compete on Direct Care

Navigant's draft model uses a price based methodology and incentivizes facilities to lower their direct care costs in order to achieve the largest profit margins. For facilities with low direct care costs, there is no incentive to change their current business model and direct more investment to direct care. Navigant's draft model proposes what they described at the September public hearing as a "penalty" for facilities that are under 95% of the state median for direct care costs. However, the mechanism in the draft model functions as a cap on profits rather than a penalty.

For instance, in Navigant's Simulation 1, the median direct care cost for the North Small group was $80.78. For facilities that are at the median (or anywhere in the 95%-105% of the median window for direct care costs) they would be reimbursed at the DC price of $84.82 (105% of the median), with reimbursement ranging from $0.00 to $8.08 over their costs ($4.04 for a facility at the median). However, for a facility at 85% of the median, spending $68.66, they would be reimbursed $76.74 ($84.82-($80.78*.95-$68.66)) – accruing $8.08 in profits per patient day. Under this model, facilities could remain drastically under the floor – investing less in direct care – while continuing to earn consistent margins and large profits on direct care costs. Conversely, a facility in the North Small group that currently has direct care costs 20% above the median would see a $12.12 loss per patient day, and unlike facilities below the floor, there is no cap on losses for facilities above the ceiling.

A price based reimbursement system may also have the unintended consequence of further distancing facilities from the quality outcomes to which they aspire. Facilities that currently have good quality outcomes, but which exceed 105% of the median in direct care costs, could see significant reductions in payment rates under the proposed system. Those facilities would then struggle to capture quality incentive payments. It would be difficult for them to continue to provide their historic high quality while experiencing potentially drastic cuts to their direct care reimbursement.

Under any pricing model seeking to incentivize adequate spending for direct care costs, there needs to be a mechanism disincentivizing facilities from remaining consistently below the median while realizing significant profits. Navigant should consider phasing out the current formula for facilities below the 95% floor, which reimburses facilities at rates well above their costs. Alternatively, Navigant could earmark the reimbursement revenue above facility costs for direct care work. A direct care pass-through would help ensure that facilities would not prioritize profits over investing in direct care services. For facilities that currently invest heavily in direct patient care, Navigant should raise the ceiling so that those facilities don't face precipitous cuts which could diminish resident care.

Quality Incentives Payments Should Prioritize Direct Care and use Consistent Methodology

Include Comprehensive Quality Measures

Navigant's draft model outlines possible measures for assessing nursing home quality as it relates to quality based reimbursement. A new prospective payment system should include the whole suite of quality measures that the Centers for Medicare and Medicaid Services (CMS) collects and publishes through the Nursing Home Compare system. Using an inclusive approach would minimize facility incentives to focus on specific quality measures that effect reimbursement. With such a narrow focus, the reimbursement system could end up rewarding facilities for their performance on (or potential gaming of) only a limited set measures rather than assessing and rewarding facilities for holistic quality outcomes.

Include Additional Staffing Metrics in Quality Incentive Reimbursement

Direct care staff are fundamental in providing quality care and support to our nursing home residents. The quality incentive portion of Florida's prospective payment model should underscore this reality and reward facilities that prioritize frontline caregiving, and the measures making up staffing and workforce metrics should account for more than 15% of the quality model methodology they currently receive. Specifically, the model should:

- Separate Measures for Distinct Job Categories:
  RNs, LPNs, and CNAs provide different job functions in nursing homes. In Navigant's Draft Model they are grouped together (along with social work and activity staffing) in a measure titled Combined Direct Care Staffing plus Social Work and Activity Staffing. While all of these jobs are important to quality of care in nursing homes, they have different duties, are not interchangeable, and should be measured independently (e.g. social work duties do not include toileting residents). Treating staffing in this combined way overlooks the complex needs of nursing home residents and fails to adequately

reward facilities that acknowledge the variety of resident needs and staff all titles appropriately. We suggest that the quality model include separate measures for each of the following: RN, LPN, CNA.

- Direct Care Staff Retention Measure:
  Studies show that direct care staff retention is positively correlated to better quality outcomes. CMS recently implemented the Payroll-Based Journal system which mandates all skilled nursing facilities submit staffing data to CMS, including hire and termination dates for direct care employees (including contract staff). This new data should be used to measure staff retention by job title (separately calculated for RNs, LPNs, and CNAs) and facilities should be awarded points in the quality model for greater retention than the statewide median.
- Wages and Benefits Incentive:
  The direct care workforce in nursing homes is often underpaid and lacks comprehensive health insurance. This industry-wide practice leads to many direct care workers working back to back shifts at multiple facilities resulting in a tired and overworked workforce with compromised immune systems. Conversely, living wages and comprehensive benefits have been shown to have positive impacts on job quality, staff retention and quality care. Florida should reward nursing homes that provide health insurance and wages over the state median. Such a measure would acknowledge that nursing homes are communities for residents and are also part of the broader community in which they are located, responsible for providing good quality care and good quality jobs.

Exclude Secondary Source Rating Systems

The current draft model mixes primary data with secondary source ratings. Secondary source rating systems – such as the Florida Gold-Seal and the CMS Five-Star Quality Rating systems – are unnecessary, overcomplicated, and rely on external methodology that can fluctuate.

The CMS Five Star Quality Reporting system ("Five Star") provides consumers with a quick reference to judge skilled nursing facilities against one another. Such a composite is helpful for consumers who may not have the knowledge base to delve into individual quality measures and their relationship to overall nursing home quality. However, the Five Star system relies on underlying quality measure data to create composite scores for all facilities in the country. The state is currently endeavoring to define quality, and has much more robust information and comprehension of quality concerns and determinants than individual consumers. As such, the state should rely on the underlying data when determining its methodology for quality incentive portions of Medicaid reimbursement. The Five Star system already includes some of the quality measures that are currently counted as stand-alone measures in the draft methodology. This would give extra weight to certain measures, cloud the overall quality methodology and unnecessarily rely on secondary source data in defining quality as it relates to incentive payments.

The Gold Seal Award in particular is inappropriate for use in reimbursement methodology. While facilities should strive to reach all markers of quality, the Gold Seal Award is only awarded to facilities that apply for recognition and is awarded by a panel with governor appointees and provider association representatives. Having a reimbursement methodology that

is politicized in this way would raise issues of conflicts of interest and concerns over changes in the methodology having disproportionate impacts on the winners and losers of "quality" determinations in a prospective payment system.

Include Better Recognition of Performance Improvements

The draft model awards up to 0.5 points for each process and outcomes measure, however we are concerned that the threshold of a 20% year-over-year improvement is quite high for a facility to achieve. Additionally, there should be an opportunity for a facility to receive some points for improving their staffing and workforce related measures.

We also recommend that a facility that does meet the state minimum staffing standard at any point during the year is not eligible for a quality incentive payment. This is a feature in another state's quality incentive supplemental payment system.

Include Revenue from all Cost Centers and Phase in Quality Incentive Payments

We recommend shifting costs from all cost centers, including property, rather than solely operations, to fund a quality pool thereby reducing the overall impact on any individual cost center. Under the current proposal the aggregate capital costs are not reduced to contribute to the quality incentive payment pool, yet the direct care, indirect care, and operating costs are reduced by nearly 3%. If the quality incentive payments are to be 7% of current non-property spending, then the capital costs should also be reduced by a similar amount as the other cost centers since this sets up a dynamic of direct and indirect care costs being reduced for several facilities yet property reimbursement could be the same or potentially more than current levels.

We also recommend phasing in the quality incentive portion of the reimbursement, using only the supplemental payments in year 1, totaling $131 million. This will give facilities time to adjust and will allow any facilities losing money under a new reimbursement system to adjust their operations to continue providing good quality care with less revenue.

<u>Include a Growth Cap on Fair Rental Value System</u>

According to Navigant, there is not sufficient data to accurately calculate a facility's age based on improvements, so building age was reduced to 75% of the original age for each facility, and the aggregate amount of the FRVS system was inflated by a factor of 1.458 in order to maintain the budget neutrality goal. One concern is that after accurate facility age is obtained, the FRVS aggregate spending could be higher or lower than the current capital costs levels. Therefore it is important to include a growth cap on the FRVS system that will still incentivize facilities to make improvements, but not at the cost of reducing direct and indirect care reimbursements. For example, when California switched to a facility-specific prospective payment system it included an aggregate growth cap of 8% on FRVS costs compared to the previous year, however this new reimbursement methodology involved a substantial increase in new spending and was not designed to be budget neutral. Additionally, if the new FRVS systems results in aggregate costs that are lower than current levels, the savings should be dedicated to the new quality incentive payment pool rather than applying an adjustment factor.

The FRVS variables that are used should be set at levels that are reasonable and do not result in major increases in the capital cost component to the detriment of direct and indirect resident care. We have some concerns with some of the proposed variables, for example the price per square foot seems quite generous at $200.72. In California, which has some of the highest property values in the country, a $161.42 price per square foot based on the R.S. means building construction data is being used for the most recent rate year. We recommend that Navigant compare the price per square feet that other states are using. Additionally, setting the equipment value at 10% of pre-depreciation building value rather than a standard amount per bed sets up a disadvantage for facilities that have lower building values due to geography when they likely have comparable equipment costs to facilities in higher valued zip codes. We also recommend that maximum facility age be increased beyond 30 years so there is incentive for older buildings to make improvements.

Minimize Operational Disruption through Reimbursement Transition

We continue to support a reasonable phase-in of any new reimbursement system in order to ensure operational stability for facilities and uninterrupted quality care for Florida's nursing home residents.

Standardize Cost Report Filings

As Florida undergoes dramatic changes to simplify their reimbursement system the Agency for Health Care Administration should set a statewide standard for fiscal year filings with uniform start and end dates.