August 18, 2016 Remarks by Erwin Bodo

Good afternoon,

I am Erwin Bodo, representing LeadingAge Florida, an association of primarily nonprofit long-term care providers.

In preparation for this and subsequent PPS study meetings our organization has developed several concepts we would like to see incorporated into the final price-based PPS plan for nursing homes.

We agree with and our model concepts adhere to the AHCA's guiding principles of:

- Quality,
- Access,
- Equity,
- Predictability, and
- Simplicity.

I would like to touch on each of the LeadingAge Florida proposed PPS plan concepts, but first let me congratulate the Navigant Team for a cohesive and comprehensive document they produced for this meeting.

A "price" for a service must represent its real value to the consumer. If we are to move to a price-based payment plan, then Quality must be a critical and integral component of the price calculations. Significant quality improvements have been made in the past 15 years.

Nearly 4% of the nursing homes achieve Gold Seal status and licensure survey deficiencies have significantly declined. We must not implement a new payment system with unintended consequences that erode these gains.

1812 Riggins Road | Tallahassee, Florida 32308
P 850.671.3700 | F 850.671.3790 | LeadingAgeFlorida.org

Under our current payment system, high quality providers with concomitant high cost of care are generally under-reimbursed due to rate ceilings, growth limitations, and continual budget cuts. To a large extent, these providers subsidize the cost of care for Medicaid residents.

In economic terms each nursing home's operating costs can be described as a composite of an average statewide operating cost and variations due to:

- Geographic location,
- Facility size,
- Quality of care,
- Number of staff,
- Longevity of staff,
- Operational control/structure,
- Resident resource utilization,
- Efficiency/productivity, and
- Other unknown factors.

A price-based system can be fair and equitable only if the adjustments to the statewide, unadjusted price can be made for each nursing home to account for legitimate variations due to geographic location, size, quality, and staffing and other relevant factors. On the other hand, a fair and equitable price-based system must ignore variations in control/structure and other irrelevant factors that should not influence how much the State pays for the cost of care. The fewer relevant factors that are taken into consideration, the more the facility specific price will move toward the statewide average and result in large losses and gains compared to the current cost–based model.

For our model, we segregated the current nursing home budget into two components:

- property related and
- all other costs.

We suggest budget neutrality should be determined separately for these two components. Our model and related recommendations are for the components unrelated to property.

We chose the sum of the current Operating, Indirect Care, and Direct Care Class Ceilings as the Class Price. These starting

values take into consideration existing size and geographic variations. Any other starting value, such as a percentile or the fixed percent of the median cost, based on the class dynamics could serve the same purpose.

We adjust 10% of the Class Price with a Quality Factor. For our model, we chose the CMS developed overall score used in the national Nursing Home Compare as an integral component of nursing home care price. We use this measure of quality as an example. Virtually any other research-based measure or combination of measures of quality would also be appropriate as an alternative. Our proposed adjustment ranges from -10% to +10% of the
Class Price.

Additionally, based on current research that indicates high correlation between quality of care and nursing staff levels, we incorporated into the price a 5% factor related to total direct care nurse ratios. (Not unexpectedly, direct care nurse ratios also correlate with nursing facility costs.) This adjustment rewards facilities with high staffing (up to 150% of the statutory minimums).

High staffing in and of itself does not guarantee high quality. So, in retrospect, a variation on this theme would be to allow the staffing adjustment to apply only to those facilities that also have high quality measures.

Finally, we establish upper and lower price corridors at 105% and 95% of the current payment rate. This adjustment recognizes that there are other legitimate cost variations not accounted for by the previous two adjustments that should also be incorporated into the facility specific price.

We did not make any case-mix adjustment due to lack of data. We are not opposed to such an adjustment.

The specific formulas for the above two adjustments are detailed in the published PowerPoint presentation on the AHCA PPS Study webpage.

To obtain budget neutrality we proportionately reduce all nursing home specific prices.

We believe that our model meets all of AHCA's guiding principles as well as the LeadingAge Florida guiding principles we submitted for the previous PPS Study public meeting.

- Clearly, the methodology is simple, in fact much simpler than the current reimbursement plan.
- If in future years, prices are adjusted for inflation with an appropriate market basket index, the system has high budget predictability.
- Quality is well accounted for.
- We believe that the system is equitable since legitimate cost variations are accounted for.
- With the exception of some complex care, such as ventilator care, the current system provides very good access to care. Our proposed model prevents large losses and windfall gains and therefore should offer equally good access. Additionally, if a case-mix component is incorporated then the issue of adequately paying for complex care can also be addressed.