LeadingAge™ Florida

Comments for the December 8, 2016 PPS Public Meeting

On behalf of LeadingAge Florida member nursing homes we would like to express our appreciation for the transparency with which the Nursing Home Prospective Payment Study process was conducted. We very much appreciate the numerous opportunities, both public and private, we were afforded to provide input to the design of the models. However, despite model improvements made in an effort to adequately recognize and reward high quality care and redistribute available funds equitably, we are convinced that the basic structure of the proposed models is fatally flawed and the stated objectives for the new payment plan of a system that promotes quality, ensures access and reflects simplicity and equity cannot be obtained without a complete model redesign.

All of the current models assume that a fair price for the non-property related cost components can be obtained by a formula that starts with the median cost (or a fraction of the median cost) as the price and supplements to that price for each nursing home based on points attained in a quality matrix. This underlying structure reflects neither the economic conditions of nursing home operations nor the value of the services provided. Navigant modeling as well as our own efforts demonstrated that even the best of the models that start with the median and apply quality adjustments result~~s~~ in extreme losses and gains. Imposing limits on losses and gains mitigates the magnitude of the changes but does not resolve the problems. Even more problematic are the losses imposed on some very high quality facilities while substantial gains are afforded to some poor performing nursing homes.

Prices set for each facility must bear a close relationship to the value of the services the facility provides. The more "value of service" influencing factors we incorporate into the pricing model, the more likely we will achieve fair and equitable prices. In addition to explicit measures of quality, such factors include resource utilization of residents and staffing levels. Neither of these factors is included in the models studied to date. Resource utilization was considered, but was not included as a concession to the statutorily mandated high direct care staffing ratios. Perhaps a case-mix based model would result in a more equitable distribution of funds. Staffing adjustments were suggested early on by LeadingAge Florida, but were not included in any of the models.

Numerous research studies have established that the most critical factor for the quality of care in a nursing home is the size of the direct care staff, specifically licensed nurses and certified nursing assistants. In addition, studies have shown the value of low staff turnover rates and high staff stability rates. We believe any pricing model that meets the guiding principles of the study must start with either current facility specific costs or current facility specific payment rates. The starting point could then be adjusted for both direct care staffing levels and quality to obtain the final price.

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Prior to as well as during the course of the study, LeadingAge Florida suggested that elimination of retroactive rate adjustments, the putative reason for the study, can be easily achieved without a complete rewrite of the current payment plan. We also suggested that administrative simplicity can be obtained by establishing the current payment rates as facility specific prices that can be adjusted annually for inflation and quality gains or losses. Budget predictability, another desired trait for the new plan, already exists since nursing home payments are frozen at a statutorily fixed level and budget increases are due entirely to increases in caseload.

We also would like to reiterate several of our earlier suggestions:

- Please include at least Palm Beach County in the definition of the South Region. Based on our analyses as well as the Florida Consumer Price Index, several other large metropolitan areas of the state are also appropriate for inclusion in the higher priced region.
- While the 30th percentile quality point threshold for awarding Quality Incentives is a definite improvement, it prevents lower quality homes from obtaining Quality Incentives for year-to-year improvements. We recommend that the 30th percentile threshold exclude points awarded for year-to-year improvements.
- Please remove the American Health Care Association (AHCA) Quality Silver and Gold Awards from the Quality Matrix. These awards are available only to AHCA members and therefore create inequity in the model.

We also urge that the study report note the feasibility of alternative pricing models, such as those we have suggested in previous correspondence, a need for reasonable limits on losses and gains, and the necessity for a reasonable phase-in period.

Several critical plan elements listed below have not been addressed. These questions must be resolved before any new payment plan is proposed for implementation.

- For what facility or system-wide changes will initial facility prices be adjusted?
- How often will the system be recalibrated to account for facility specific changes?
- How and how frequently will inflation adjustments be made?
- What time frame will be used for the Quality Matrix components?
- How will new provider rates be set?
- Will the cost reporting and desk and field audits continue?
- How often will the quality matrix be updated?
- How will FRVS rates be adjusted for bed additions?