

# AHCA NURSING HOME PROSPECTIVE PAYMENT SYSTEMS

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**PUBLIC HEARING**

JUNE 30, 2016

1:00 P.M. – 4:00 P.M.

NAVIGANT

# AGENDA

Welcome

Background/Legislation

Project Overview/Timeline

Guiding Principles

Objectives

Stakeholder Input/Questions

Options/Payment Methodology

Public Comment

Adjourn



# PROJECT OVERVIEW

# SPECIFIC APPROPRIATION 186 OF THE 2016 GENERAL APPROPRIATIONS ACT

*From the funds in Specific Appropriation 186, \$500,000 in nonrecurring funds from the Medical Care Trust Fund is provided to the Agency for Health Care Administration to contract with an independent consultant **to develop a plan, collaboratively with all interested stakeholders, to convert Medicaid payments for nursing home services from a cost based reimbursement methodology to a prospective payment system.** The study should recommend a payment system that **promotes quality, ensures access, and reflects simplicity and equity.** The study should outline **steps for a phase in process to ensure providers have time to adjust to payment changes.** The study shall identify steps necessary for the transition to be completed in a **budget neutral** manner. Additionally, the report shall address the **impact of a prospective payment system on Medicaid reimbursement rates for Hospice providers.** The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2017.*

# NURSING HOME PPS STUDY

## Objectives

Develop a plan to convert from current cost-based reimbursement methodology to a new prospective payment system

Collaborate with all interested stakeholders

Outline steps to implement a new payment method

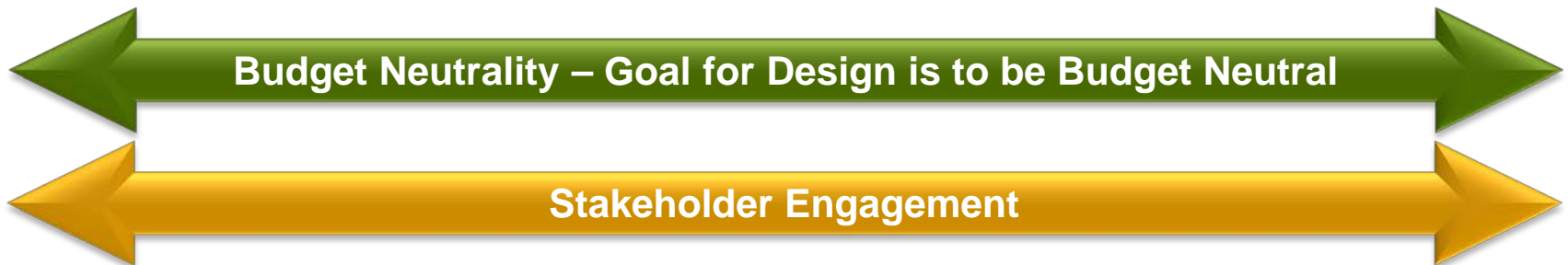
Address the impact of a prospective payment system on Medicaid reimbursement rates for Nursing Home and Hospice providers

**Timing** - The report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2017

# GUIDING PRINCIPLES

When designing the new PPS methodology, Navigant will evaluate each option based on the following guiding principles:

Quality	Access	Equity	Predictability	Simplicity
<ul style="list-style-type: none"><li>Does the methodology promote and reward high quality long-term care provision?</li></ul>	<ul style="list-style-type: none"><li>Does the methodology promote and maintain access to care for people who require long-term care, including hard to serve patient populations?</li></ul>	<ul style="list-style-type: none"><li>Does the methodology promote equity in payment across providers for care and properly address various cost centers?</li></ul>	<ul style="list-style-type: none"><li>Does the methodology improve the ability for AHCA and providers to adequately plan and budget?</li></ul>	<ul style="list-style-type: none"><li>Is the methodology easy to understand and replicate?</li></ul>





# STAKEHOLDER ENGAGEMENT

# STAKEHOLDER ENGAGEMENT

- Navigant has met with the following groups to discuss concerns with current system along with considerations for new prospective system:
  - 5/17 – LeadingAge Florida
  - 5/18 – Florida Association of Health Plans
  - 5/18 – Florida Health Care Association
  - 5/19 – Florida Hospice & Palliative Care Association
  - 5/25 – Florida Department of Elder Affairs – Long-Term Care Ombudsman
  - 6:30 – Public Hearing



# STAKEHOLDER INPUT PROCESS



# SUMMARY OF STAKEHOLDER FEEDBACK

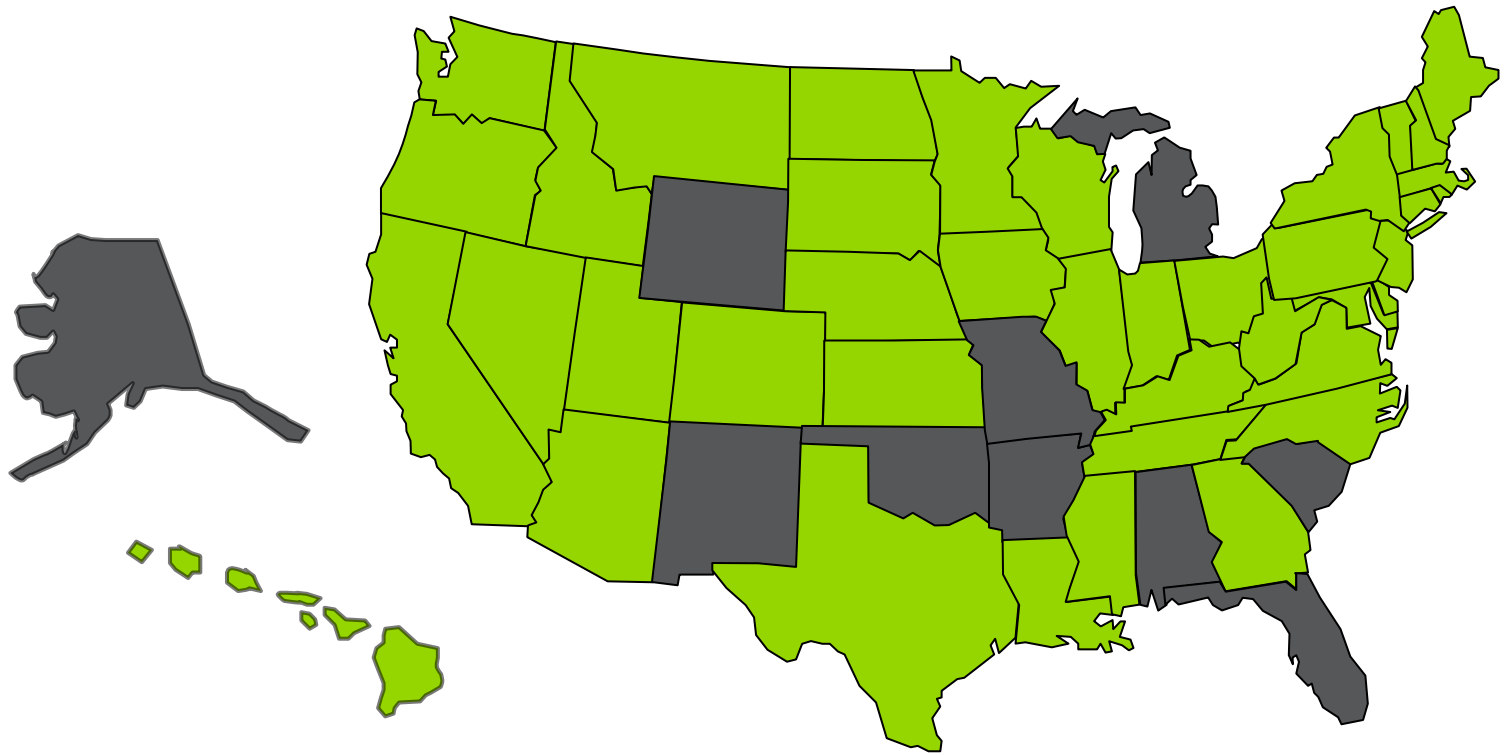
Topic	Example Stakeholder Comment
Implementation timeline	<ul style="list-style-type: none"> <li>• New system should stress transparency and smoothly transition over several years to minimize big winners and losers</li> <li>• Looking for incremental changes with a phase-in approach</li> </ul>
Quality Incentives	<ul style="list-style-type: none"> <li>• CMS 5-Star Rating Scale fails to appropriately evaluate nursing facilities</li> <li>• CMS 5-Star Rating does not address patient satisfaction</li> <li>• Providers should not be penalized for low quality, should only be used as add-on to rate</li> <li>• Top current quality issues include:               <ul style="list-style-type: none"> <li>• Dignity/respect/staff attitude</li> <li>• Medication admin and organization</li> <li>• Discharge eviction</li> <li>• Personal Hygiene</li> <li>• Response to calls</li> </ul> </li> <li>• Governor's Gold Seal is a valuable quality measure</li> <li>• Quality incentive program should have no more than a three percent financial impact on rates</li> <li>• Time spent with patient should be included in quality measures</li> <li>• Should incentivize low turnover and length of ownership</li> <li>• MCOs are using hospital readmissions and ER visits as quality measures</li> </ul>
Acuity-based system	<ul style="list-style-type: none"> <li>• If acuity-based system is used, must take into account the current staffing standards</li> <li>• An acuity-based system cannot work with Florida's high staffing requirements</li> </ul>

# SUMMARY OF STAKEHOLDER FEEDBACK

Topic	Example Stakeholder Comment
Access to care	<ul style="list-style-type: none"> <li>• Ventilator and dementia add-ons could help to prevent access issues</li> <li>• There is currently an access to care issue for ventilator patients</li> <li>• Access to care issues regarding ventilator-dependent and dialysis patients</li> <li>• Diabetes is a complex disease that is not appropriately reimbursed</li> <li>• Pediatric patients should receive higher reimbursement</li> <li>• Some rural areas have access to care issues</li> </ul>
Transition to HCBS setting	<ul style="list-style-type: none"> <li>• Proponent of incentivizing the transition of residents from institutional to HCBS setting as long as providers are being paid adequately and equitably</li> <li>• New system should stress the goal to move patients from institutional to HCBS settings</li> <li>• MCOs already have goals in place to move patients out of the institutional setting</li> </ul>
Peer groupings	<ul style="list-style-type: none"> <li>• Implementing a geographical adjuster is key due to wage differences</li> <li>• New system must recognize size of facility and geographic region</li> </ul>
Simplicity	<ul style="list-style-type: none"> <li>• Quality could be compromised if provider administrative burden is dramatically increased.</li> <li>• Simplicity on provider side should be stressed</li> <li>• Providers went from one payer to almost 10 with managed care</li> </ul>
Potential RUGs system	<ul style="list-style-type: none"> <li>• Concerned it may not account for mental/behavioral/cognitive health issues</li> </ul>
Fair Rental Value System	<ul style="list-style-type: none"> <li>• Currently, there is no help for enhancements or renovations</li> <li>• Current system does not properly account for new construction</li> </ul>

# STATES USING ACUITY-BASED SYSTEMS\*

40 States use an acuity-based reimbursement system (including D.C.)



■ States using acuity-based reimbursement

\*Information is current as of May 2014.

<https://www.macpac.gov/wp-content/uploads/2015/01/Nursing-Facility-Payment-Policies.xlsx>



# QUALITY INCENTIVE MODELS SUGGESTED BY STAKEHOLDERS

State	Quality Incentive Program
Tennessee	<ul style="list-style-type: none"> <li>• There are two components comprising the full value-based purchasing approach for nursing facility reimbursement               <ul style="list-style-type: none"> <li>○ Threshold Measures - Must be met by the facility in order to be eligible for the quality payment portion of their reimbursement rate</li> <li>○ Quality Measures - Used to determine the amount of quality payment that a facility would receive. The total number of points received on the Quality Measures divided by the maximum potential points determines the percentage of the quality payment for which they are eligible.                   <ul style="list-style-type: none"> <li>▪ Resident / Family / Staff Satisfaction – 35 Points                       <ul style="list-style-type: none"> <li>• Conducting surveys and taking action based on results</li> </ul> </li> <li>▪ Culture Change / Quality of Life – 30 Points                       <ul style="list-style-type: none"> <li>• Respectful treatment, member choice, member/family input, meaningful activities</li> </ul> </li> <li>▪ Staffing / Staff Competency – 25 Points                       <ul style="list-style-type: none"> <li>• Volume of staff, choice of staff, consistency of staff, initial and ongoing staff training</li> </ul> </li> <li>▪ Clinical Performance – 10 Points                       <ul style="list-style-type: none"> <li>• Health related measures, prevention and early detection, ongoing functional assessment</li> </ul> </li> </ul> </li> </ul> </li> </ul>
Maryland	<ul style="list-style-type: none"> <li>• Facilities are scored on measures such as staffing levels and stability, family satisfaction survey results, Minimum Data Set quality indicators, employment of an infection control coordinator, and staff immunizations</li> <li>• Each year, 0.5% of budget for nursing facility services is allocated for pay-for-performance payments</li> <li>• Funds are distributed based on each facility's relative score</li> <li>• The highest scoring facility must receive twice the amount per day as the lowest scoring facility</li> <li>• 85% of the payment pool must be distributed to the highest scoring facilities (representing 35% of eligible care days)</li> <li>• 15% of the payment pool must be distributed among eligible facilities</li> </ul>

# QUALITY INCENTIVE MODELS SUGGESTED BY STAKEHOLDERS

State	Quality Incentive Program
Utah	<ul style="list-style-type: none"> <li>• Qualifying facilities can receive a quality improvement incentive add-on payment to their reimbursement rate               <ul style="list-style-type: none"> <li>○ There are three different incentive programs through which qualifying facilities can receive payment</li> </ul> </li> <li>• For the first incentive, funds of \$1,000,000 are set aside annually to reimburse facilities that:               <ul style="list-style-type: none"> <li>○ Have a measurable quality improvement that involves residents and families and incorporates a satisfaction survey (50%)</li> <li>○ A plan for culture change with an example of how the facility has implemented the plan (25%)</li> <li>○ An employee satisfaction program (25%)</li> <li>○ No violations that are at an “immediate jeopardy” level</li> </ul> </li> <li>• Funds will be distributed based on the proportionate share of the total Medicaid patient days in qualifying facilities               <ul style="list-style-type: none"> <li>○ If a facility receives a substandard quality of care level, the facility is eligible only for 50% of the possible reimbursement</li> </ul> </li> <li>• For the second incentive, \$4,275,900 will be set aside annually to fund quality improvement projects. Providers may receive payment for:               <ul style="list-style-type: none"> <li>○ Purchasing or enhancing nurse call systems, patient lift systems, new patient bathing systems, patient life enhancing devices, vans for patient use, and existing clinical information systems/software among others</li> <li>○ Educating staff on quality</li> <li>○ Provide flu or pneumonia immunizations</li> </ul> </li> <li>• The pool of funds available for the third quality initiative is equal to the total funds that have not been distributed through the second quality improvement incentive               <ul style="list-style-type: none"> <li>○ Funds will be distributed to qualifying providers based on the proportionate share of the total Medicaid patient days in qualifying facilities</li> </ul> </li> </ul>



PAYMENT  
METHODOLOGY  
OPTIONS



# CURRENT FLORIDA PAYMENT METHODOLOGY

- General Payment Methodology
  - The Medicaid program pays a single level of payment rate for all levels of nursing care (per diem)
  - Retrospective costs are based upon each provider's allowable Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology
  - For the purpose of establishing reimbursement limits for operating, direct care, and indirect care costs, six peer groupings were developed based on the following factors:
    - **Geographic Region: Northern / Central / Southern**
    - **Size: 1-100 beds / 101-500 beds**
- Medicaid Adjustment Rate
  - Facilities with over 50 percent Medicaid utilization will receive enhanced rates
- Florida Medicaid Nursing Home Special Medicaid Payments
  - For qualified public, non-state owned or operated nursing facilities where the Medicaid per diem rate is greater than 90 percent of the facility's Medicaid per diem cost, the nursing facility shall receive a payment of \$200,000.

# CURRENT COST CENTERS

Cost Center	Cost Report Category
Direct Care Costs	The direct care subcomponent is comprised of the costs of RNs, LPNs, and CNAs to meet the direct care staffing requirements established who provide direct care.
Indirect Costs	Indirect Patient Care (Nursing Services, employee-related expenses), Dietary, Activities Services, Social Services, Medical Records, Central Supply Services
Operating Costs	Plant Operation, Housekeeping, Administration, Laundry and Linen
<i>Allowable costs allocated between Indirect and Operating Costs</i>	Physical Therapy, Speech and Audiological Therapy, Occupational Therapy, Parenteral/Enteral (PEN) Therapy, Complex Medical Equipment, Medical Supplies Charges to Residents, Inhalation/Respiratory Therapy, IV Therapy, and any costs of providing other ancillary services for which specific accounts are not established.
Property Costs	These costs are related to the ownership or leasing of land and depreciable real and personal property. Such costs may include property taxes, insurance, interest and depreciation, or rent. The costs of property pertaining to non-allowable or non-reimbursable cost centers shall be excluded.

# PRICE-BASED VS. COST-BASED

## Price-based

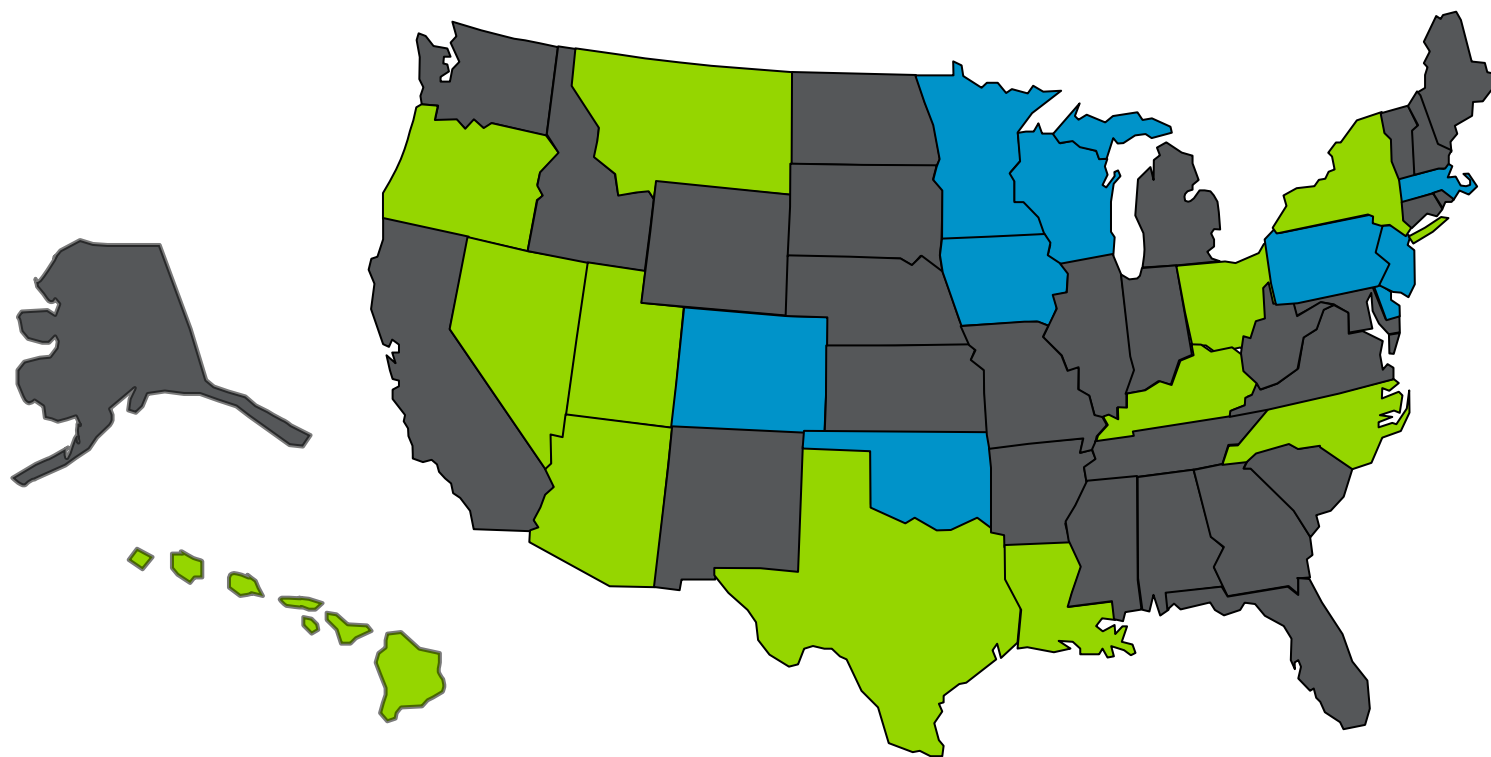
- **Implies that there is a market-based standard that can be used to establish rates**
- Implies that market provides some standardization of rates, assuming that the rates paid in the marketplace would not vary from provider to provider for the same service
- Implies a prospective payment approach, without a retrospective settlement

## Cost-based

- **Rates are established based on reported historical costs**
- Rates can be facility-specific or standardized (statewide, peer group or other)
- Cost-based methods can be applied prospectively or retrospectively
- Cost-based rate components can be adjusted to reflect resource requirements attributable to differences in resident acuity

# STATES USING PRICE-BASED VS. COST-BASED PAYMENTS\*

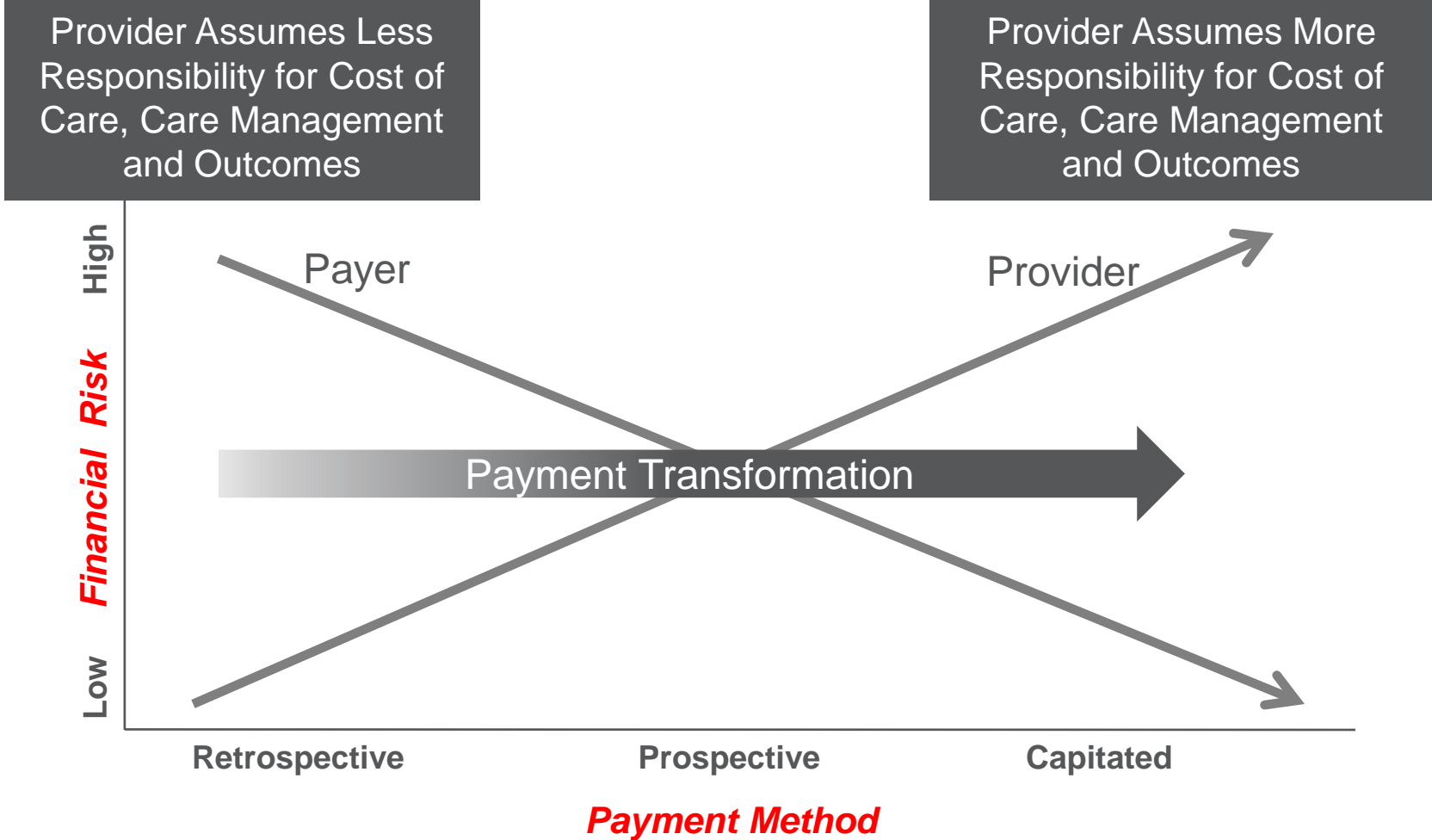
- Cost-based payments
- Price-based payments
- Combination of cost and price-based payments



\*Information is current as of May 2014.

<https://www.macpac.gov/wp-content/uploads/2015/01/Nursing-Facility-Payment-Policies.xlsx>

# PAYMENT METHODOLOGY OVERVIEW





QUALITY  
INCENTIVE  
MODELS

# QUALITY INCENTIVE MODELS

- Some states are implementing incentive payments in order to improve quality and access to care in nursing facilities
- The methods by which such incentive payments are implemented vary across states but may involve adjustments to reimbursement rates based upon how the facility performs under certain quality metrics. Examples of quality metrics that can affect reimbursement include the following:
  - MDS Quality Measures
  - Patient / family / employee satisfaction surveys
  - Staffing levels / stability
  - Occupancy levels
- Reimbursement rates may also be temporarily adjusted if the nursing facility undertakes quality improvement projects and achieves specific improvements in quality measures. For example, Minnesota has implemented the following program:
  - *Performance-based Incentive Payment Program (PIPP)* - Through the PIPP, a facility may receive a time-limited rate increase (up to five percent) by undertaking a quality improvement project and achieving specified improvements in quality measures – negotiated with the State

# CMS FIVE-STAR QUALITY RATING SYSTEM

- CMS created the *Five-Star Quality Rating System* to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes.
- NFs receive both an overall rating of one to five stars, as well as a separate one to five star rating for each of the three component areas:

## Health inspections

- The health inspection rating contains information from the last 3 years of onsite inspections, including both standard surveys and any complaint surveys.

## Staffing

- The staffing rating has information about the number of hours of care provided on average to each resident each day by nursing staff. The rating for staffing is based on two case-mix adjusted measures:
  - Total nursing hours per resident day (RN + LPN + nurse aide hours)
  - RN hours per resident day

## Quality measures

- The quality measure rating has information on 11 different physical and clinical measures for nursing home residents developed from MDS-based indicators
- The rating now includes information about nursing homes' use of antipsychotic medications in both long-stay and short-stay residents.

Rankings are posted on a CMS Nursing Home Compare website [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare)



# MDS 3.0 QUALITY MEASURES

Short Stay Quality Measures	Long Stay Quality Measures
<ul style="list-style-type: none"> <li>• Percent of residents who self-report moderate to severe pain*</li> <li>• Percent of residents with pressure ulcers that are new or worsened*</li> <li>• Percent of residents who were assessed and appropriately given the seasonal influenza vaccine</li> <li>• Percent of residents assessed and appropriately given the pneumococcal vaccine</li> <li>• Percent of short-stay residents who newly received an antipsychotic medication*</li> </ul>	<ul style="list-style-type: none"> <li>• Percent of residents experiencing one or more falls with major injury*</li> <li>• Percent of residents who self-report moderate to severe pain*</li> <li>• Percent of high-risk residents with pressure ulcers*</li> <li>• Percent of residents assessed and appropriately given the seasonal influenza vaccine</li> <li>• Percent of residents assessed and appropriately given the pneumococcal vaccine</li> <li>• Percent of residents with a urinary tract infection*</li> <li>• Percent of low-risk residents who lose control of their bowels or bladder</li> <li>• Percent of residents who have/had a catheter inserted and left in their bladder*</li> <li>• Percent of residents who were physically restrained*</li> <li>• Percent of residents whose need for help with activities of daily living has increased*</li> <li>• Percent of residents who lose too much weight</li> <li>• Percent of residents who have depressive symptoms</li> <li>• Percent of long-stay residents who received an antipsychotic medication*</li> </ul>

*\* Indicates the quality measure is used in the CMS Five-Star Quality Rating System*

## STAFFING

- In 2014, there were approximately 15,600 nursing homes in the US serving 1.4 million residents, with an average total of 3.88 nursing hours per resident day: 1.41 (1hr, 25min) nursing hours per resident day by licensed nurses (RNs, LPNs/LVNs) and 2.47 (2hr, 28min) nursing hours per resident day by nurse's aides ([CDC-Harris-Kojetin 2016](#)).



## Reporting of Assessment and Quality Data

“ ...beginning with fiscal year 2018, in the case of a skilled nursing facility that does not submit data, as applicable,... the Secretary shall reduce such percentage for payment rates during such fiscal year by 2 percentage points.”

# SNF QUALITY REPORTING PROGRAM

Domain	Outcome Measures
Skin Integrity and Changes in skin Integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay)
Incidence of Major Falls	Application of Percent of Residents Experiencing One of More Falls with Major Injury (Long Stay)
Functional Status, Cognitive Function, and Changes in Function, and Changes in Function and Cognitive Function	Application of Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
CMS requires SNSF to submit payroll and other auditable data at least quarterly.,	When combined with census information, will be used to report on the level of staff in each nursing home, employee turnover and tenure, which is expected to influence quality of care.

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PUBLIC  
COMMENT

# QUESTIONS FOR CONSIDERATIONI

- How standardized should the system be?
  - Adjust for wage differences or not?
  - Adjust for facility size or not?
  - Adjust for acuity differences or not?
  - Adjust for quality differences or not?
  - Adjust for Geography or not?
  - Adjust for Medicaid Beds?
- What should the basis for the rates be – (cost components and related parameters, etc.)?
- Should Florida use cost apportionment for differences in acuity?

# QUESTIONS FOR CONSIDERATION

- Should there be a fair rental value system for capital, and what should that look like?
  - Is Fair Rental Value appropriate?
  - Are there more appropriate systems?
- Should there be a quality incentive component,
  - What should it look like
  - How should it be funded (i.e., should there be a withhold to fund it so budget neutrality can be maintained)?
- Should there be a transition or phase-in period?
- What should the time frame be for phase in?
- Should there be an acuity based measure for reimbursement?
  - Are acuity based measure appropriate given the minimum staffing - 3.6 hour nursing hour issue?



# QUESTIONS

For questions or comments related to this study,  
please contact:

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THANK YOU.