AHCA NURSING HOME PROSPECTIVE PAYMENT SYSTEM

2ND NPPS PUBLIC MEETING

AUGUST 18, 2016

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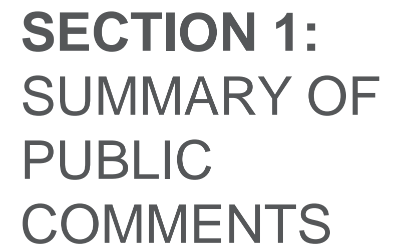

SECTION 1: SUMMARY OF PUBLIC COMMENTS

SUMMARY OF PUBLIC COMMENTS

Topic	Summary of Feedback
Overall system goals	• Only change current plan to the extent necessary to attain goals that have been set by AHCA to minimize losses and gains • A PPS that introduces payment rate variations via case-mix adjustments, quality-based adjustments, or any other facility specific adjustments could negatively affect budget predictability
Acuity-based system	• What rationale do states have for implementing a RUGs-based model as opposed to other acuity models? • Acuity adjustments must take into account high staffing standard • Will high-cost RUG rates be monitored, primarily therapy services? • If an acuity/resource utilization model is used, it should be based on the same classification used by Medicare PPS but perhaps some of the classes collapsed. • If a RUGs type case-mix based model is used, then the Indirect Care cost components that are part of the RUGs resource utilization calculations should be transferred into the Direct Care cost center and the remaining Indirect Care cost components should be combined with the Operating cost components to create an Administrative and Support cost center. • If a RUGs type case-mix based model is not used, then the Indirect Care and Direct Care cost components should be combined into a single Resident Care cost component. • Acuity should be addressed especially for pediatric residents

Implementation timeframe	• Phase-in should expand over three years
	    • Year 1: One-third new rate + two-thirds old rate,
	    • Year 2: Two-thirds new rate + one-third old rate,
	    • Year 3: 100% new rate.

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SUMMARY OF PUBLIC COMMENTS

<table>
<tr><th>Topic</th><th>Summary of Feedback</th></tr>
<tr><td>Quality Measures</td><td>

Quality measures must consider achievement and improvement within the facility
Quality measures should be achievable by all facilities
CMS 5-star quality measures

New system should use CMS quality measures used in Nursing Home Compare
CMS 5-star quality measures are “state of the art” based on rigorous research and are reasonable to use as the basis for quality based adjustments.
The 13 long-term resident related quality measures are applicable for the Medicaid population
We recommend the use of a raw overall quality score constructed similarly to that used in CMS Nursing Home Compare but based on staffing, survey compliance and the 16 long-term resident quality measures

Percentage of fund to carve out for quality measures

Ten percent is too much to carve out for quality if there is no new money coming from the legislature
A three percent limit is totally inadequate
At a minimum, the funds currently used as a Quality Assessment Add-On and the Medicaid Adjustment Rate should be used as the starting point for quality based adjustments

</td></tr>
<tr><td>FRVS</td><td>

FRVS must be updated to properly address replacements and repairs
New system should follow the recommendation made by the legislatively mandated 2009 Reimbursement Workgroup and incorporate a gross FRVS component similar to that used in Georgia.
Increase per bed limitation to more realistic reflect current property values
Implement standard property value indexing
FRVS should factor in geographic and facility size

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SUMMARY OF PUBLIC COMMENTS

Topic	Summary of Feedback

Rate Adjustments	• New system should recognize geographical region and facility size
	• There should be a payment add-on for dementia patients due to the high level of staffing needed
	• Peer groupings should be changed only if past trends show that costs are dramatically different in wages, benefits, etc.
	• New system should not adjust for Medicaid beds, but perhaps adjust for Medicaid caseload to ensure that nursing homes with very high Medicaid caseloads remain financially viable
	• A significant number of nursing home providers are operating with certificate of need conditions that require a minimum percentage Medicaid participation.
	    • These CON conditions must be modified for those providers that would incur substantial rate reductions under a new plan.
	• New system should have special add-on rates for outliers that are not part of the current service mix (such as ventilator or other medically complex care)
	    • The costs associated with these add-ons should not be carved out from the existing budget.

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QUESTIONS TO BE ADDRESSED THROUGH DATA ANALYTICS

- What are the measurable nursing facility characteristics that should be considered when establishing Medicaid payment rates?
  - Differences in resident acuity?
  - Relative efficiency?
  - Facility location?
  - Average facility occupancy?
  - Average Medicaid utilization percentage?
  - Size of facility (number of beds)?
  - Age of facility?
  - Differences in quality?

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QUESTIONS TO BE ADDRESSED THROUGH DATA ANALYTICS

- For those characteristics determined to be drivers of costs that merit consideration, how should rates be adjusted to reflect the differences?
  - Facility-specific rate or rate component factor?
  - Benchmark rate component ceiling or floor?
  - Set rate components by facility specialty or "peer group"?

- What data should be used to analyze facility characteristics?
  - Minimum Data Set (MDS) data elements
  - Nursing facility cost report data
  - Quality measurement data elements
    - MDS
    - Periodic OSCAR and other surveys

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IDENTIFYING MEDICAID VS NON-MEDICAID RECIPIENTS

- Identified MDS records as belonging to Medicaid recipients if,
  - Medicaid recipient ID field on MDS record was populated with a numeric value at least 8 characters in length. (correct Medicaid recipient IDs are 10 digits long.)

  Or

  - Plus sign (+) in Medicaid recipient ID field on MDS record indicating a Medicaid number is pending

  Or

  - SSN on the MDS record mapped to a Medicaid recipient eligibility record and the recipient was Medicaid eligible on the assessment date listed on the MDS record
- Selected last MDS assessment record for each recipient that occurred during the timeframe of the facility's latest cost report – one MDS record per recipient
- Result,
  - 44% of all recipients are Medicaid recipients
  - 79% of all nursing facility days attributed to Medicaid recipients

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IDENTIFYING MEDICAID VS NON-MEDICAID RECIPIENTS

Medicaid Number Value (Cell A0700)	Count	Percent of Medicaid versus Non-Medicaid	Percent of Total
10 Digit	84,913	80%	
8 or 9 Digit	1,243	1%	
+ (Pending Medicaid number)	2,846	3%	
Match based on Medicaid eligibility data	17,687	16%	
Medicaid Total	**106,689**	**100%**	**44%**
N	75,761	56%	
^	58,363	43%	
Other	1,190	1%	
Non-Medicaid Total	**135,314**	**100%**	**56%**
Total	**242,003**		**100%**

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SUMMARY STATISTICS - MDS DATA

OBRA ASSESSMENT TYPES

A0310A FEDERAL OBRA	Description	Records
01	Admission assessment (required by day 14)	58,698
02	Quarterly review assessment	51,902
03	Annual assessment	10,508
04	Significant change in status assessment	8,503
05	Significant correction to prior comprehensive assessment	39
06	Significant correction to prior quarterly assessment	6
99	None of the above	112,347
Total		**242,003**

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SUMMARY STATISTICS - MDS DATA

MEDICARE SNF PPS ASSESSMENT TYPES

A0310B PPS	Description	Records
01	5-day scheduled assessment	42,548
02	14-day scheduled assessment	41,342
03	30-day scheduled assessment	26,065
04	60-day scheduled assessment	6,688
05	90-day scheduled assessment	2,717
06	Readmission/return assessment	1,265
07	Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)	11,099
99	None of the above (not a PPS assessment)	110,279
Total		**242,003**

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CASE MIX SUMMARY USING RUG IV

Recipient Type	Record Count	Case Mix Index
Medicaid	106,689	1.14
Non-Medicaid	135,314	1.30
Total	**242,003**	**1.23**

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REHABILITATION SERVICE REVIEW USING RUG IV

Recipient Type	Rehab Count	Total Records	Percent
Medicaid	41,432	106,689	39%
Non-Medicaid	114,729	135,314	85%
All	**156,161**	**242,003**	**65%**

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SUMMARY STATISTICS - MDS DATA

TOP 20 MEDICAID RUG CLASSIFICATIONS

RUG Code	RUG Description	Relative Weight	All Records	Medicaid Records	Percent Medicaid
RAE	Rehabilitation All Levels / ADL 15 – 16	1.65	8,914	3,396	38%
RAD	Rehabilitation All Levels / ADL 11 – 14	1.58	30,145	9,378	31%
RAC	Rehabilitation All Levels / ADL 6 – 10	1.36	75,281	18,360	24%
HD1	Special Care High with No Depression / ADL 11 – 14	1.33	1,956	1,527	78%
LE1	Special Care Low with No Depression / ADL 15 – 16	1.26	3,504	2,878	82%
HB1	Special Care High with No Depression / ADL 2 – 5	1.22	3,748	1,413	38%
LD1	Special Care Low with No Depression / ADL 11 – 14	1.21	4,768	3,828	80%
PE1	Physical Function with No Rest.1 Nursing / ADL 15 – 16	1.17	4,058	3,313	82%
CD1	Clinically Complex with No Depression / ADL 11 – 14	1.15	3,737	2,815	75%
RAB	Rehabilitation All Levels / ADL 2 – 5	1.1	31,294	6,772	22%
PD1	Physical Function with No Rest.1 Nursing / ADL 11 – 14	1.06	8,365	6,923	83%
LC1	Special Care Low with No Depression / ADL 6 – 10	1.02	3,959	3,120	79%
CC1	Clinically Complex with No Depression / ADL 6 – 10	0.96	5,208	3,695	71%
PC1	Physical Function with No Rest.1 Nursing / ADL 6 – 10	0.85	13,137	10,715	82%
RAA	Rehabilitation All Levels / ADL 0 – 1	0.82	10,527	3,526	33%
BB1	Behavior/Cognitive with No Rest.1 Nursing / ADL 2 – 5	0.75	3,512	3,060	87%
PB1	Physical Function with No Rest.1 Nursing / ADL 2 – 5	0.65	3,819	3,027	79%
CA1	Clinically Complex with No Depression / ADL 0 – 1	0.65	2,663	1,878	71%
BA1	Behavior/Cognitive with No Rest.1 Nursing / ADL 0 – 1	0.53	2,829	2,585	91%
PA1	Physical Function with No Rest.1 Nursing / ADL 0 – 1	0.45	4,964	4,270	86%

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SUMMARY STATISTICS - MDS DATA

RUG CATEGORY BREAKDOWN

RUG Category	Medicaid Weighted Average Case Mix	All Records	Medicaid Records	Percent Medicaid
Extensive Services	2.34	4,678	2,282	49%
Rehabilitation All Levels	1.35	156,161	41,432	27%
Special Care High	1.33	9,622	5,733	60%
Special Care Low	1.16	13,600	10,842	80%
Clinically Complex	0.98	15,310	10,846	71%
Behavior/Cognitive	0.65	6,569	5,855	89%
Reduced Physical Function	0.86	35,890	29,632	83%
Default	0.45	173	67	39%

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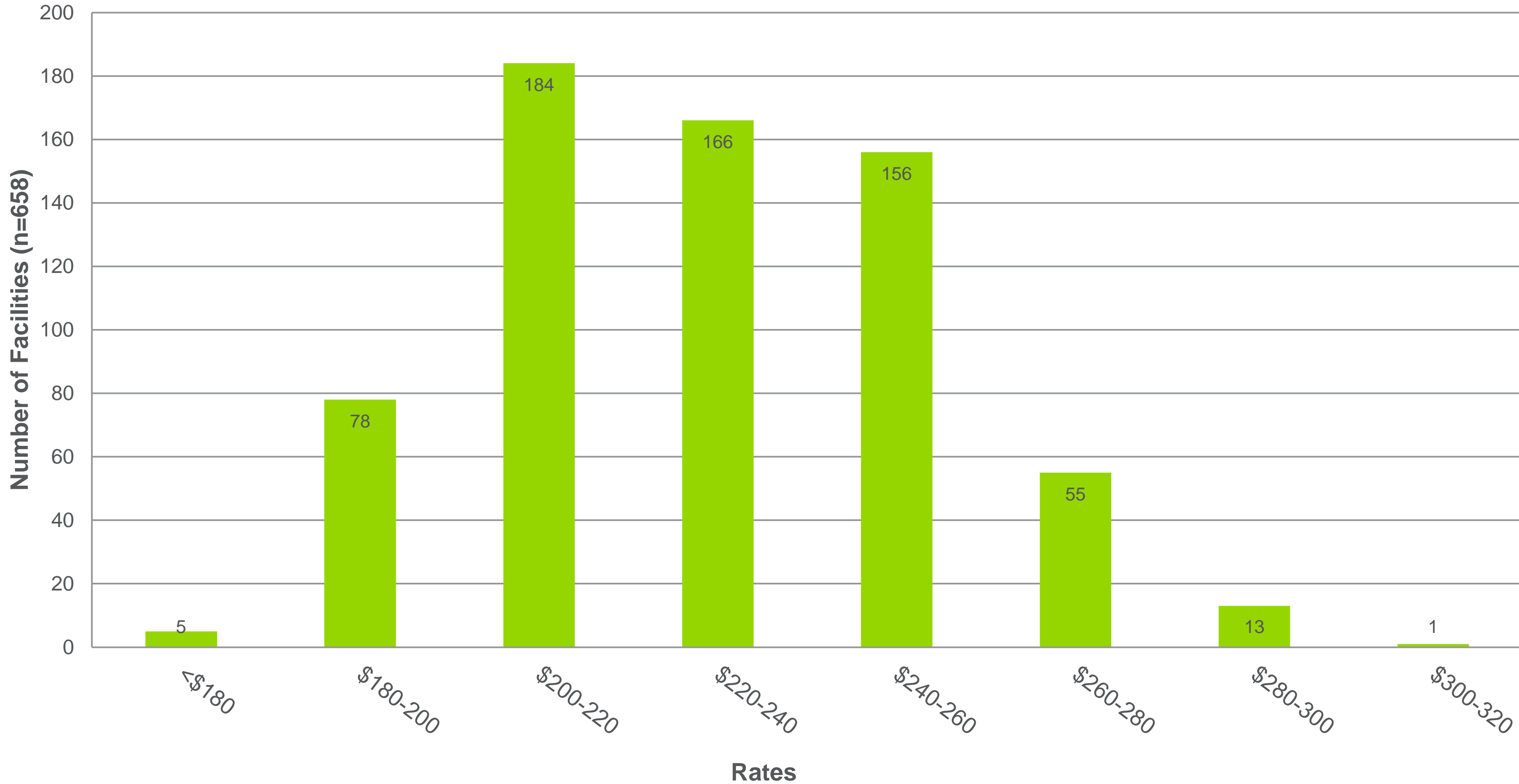
DISTRIBUTION OF FY 2016 RATES



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MEDIAN FACILITY COSTS BY REGION / SIZE, PER RESIDENT DAY

	Median Calculated Separately for Central Region		
Region/Size	Median Direct Care Costs	Median Indirect Care Costs	Operating Costs
Northern/Small	$84.71	$60.88	$54.51
Central/Small	$86.50	$58.67	$57.88
Southern/Small	$98.08	$76.61	$64.38
Northern/Large	$88.34	$53.77	$49.15
Central/Large	$84.39	$52.90	$49.70
Southern/Large	$89.35	$59.13	$54.70

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NURSING FACILITY COST DRIVERS

- **Differences in resident acuity:** Differences in acuity, as measured by the RUG-IV classification model and the CMS relative weights, appears to have an inverse relationship to cost per day values. As measured acuity increases, cost per day values go down.
- **Relative efficiency:** When the impacts of other potential cost drivers have been adjusted for, relative efficiency can be measured by differences in cost per day values, based on the assumption that lower cost facilities are more efficient than higher cost facilities.
- **Facility location:** Facilities in Florida's southern regions generally have higher direct and indirect care cost per day values.
- **Average facility occupancy:** Facilities with higher occupancy rates generally have lower direct, indirect and operating cost per day values.

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NURSING FACILITY COST DRIVERS

- **Average Medicaid utilization percentage:** Facilities with higher Medicaid utilization percentages generally have lower direct, indirect and operating cost per day values.
- **Size of facility (number of beds):** Facilities with more licensed beds generally have lower cost per day values, but cost differences may not be significant.
- **Age of facility:** Older facilities generally have higher cost per day values.
- **Differences in quality:** There are no cost differences between facilities with lower CMS quality scores and those that have higher quality scores.

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REGRESSION ANALYSES OF VARIABLES (PER DAY)

Variables	Total Care Cost	Direct Care Cost	Indirect Care Cost	Operating Cost
Case Mix Index	($41.62)	($23.51)	None	($12.75)
Urban Areas	None	$4.11	None	None
South	$10.88	$3.41	$3.58	$3.88
North	None	None	None	None
Medicaid Utilization (by percentage point)	($0.65)	($0.18)	($0.32)	($0.14)
Occupancy (by percentage point)	($0.32)	($0.09)	($0.08)	($0.14)
# Beds (by additional bed)	($0.05)	$0.01	($0.03)	($0.04)
Licensed Nursing Hours (per day)	$52.17	$26.17	$13.44	$12.55
CNA Hours (per day)	$16.32	$10.35	None	~$3.22
Facility Age (by year)	$0.21	$0.12	$0.11	None

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REGRESSION ANALYSES OF VARIABLES (PER DAY)

Star Rating (by additional Star)	Total Care Cost	Direct Care Cost	Indirect Care Cost	Operating Cost
CMS Quality Measure Rating	None	None	None	None
CMS Health Inspection	$1.29	$0.84	$1.35	($0.89)
CMS Staffing Rating	None	None	None	None
CMS RN Staffing	$3.72	$1.50	$1.57	None

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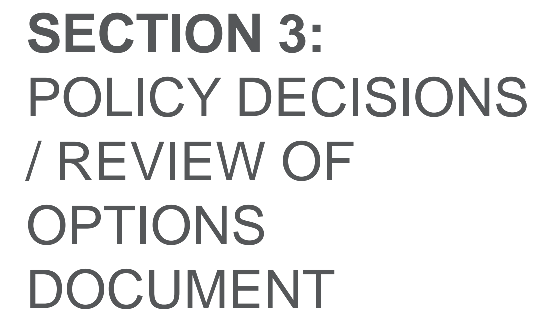
SECTION 3:
POLICY DECISIONS / REVIEW OF OPTIONS DOCUMENT

POLICY DECISION LIST

RATE ADJUSTMENTS

Consideration	If yes, then …	Tentative Decision
Adjust for acuity	• What basis? o RUGs o Other measure – ventilator; behavioral/wandering; other o What per diem components affected	No case mix adjustment
Adjust for delivery of specialized services	• What types of services	Possible adjustment for specialized services
Adjust for differences in quality	• What quality measures • How to determine the adjustment amounts • Incentive and/or penalty • Portion of overall budget	No decision made
Adjust for regional differences in wages	• By Medicare wage area; by state-defined region(s); by counties; by urban versus rural; other • Adjust by Medicare wage index; adjust by average or percentile of each grouping	SMMC Regions 10 and 11
Adjust for differences in facility size	• What number of bed ranges make sense • What per diem components affected	No size adjustment

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OTHER

Consideration	Options	Tentative Decision
Per diem components	• Direct/nursing; Indirect; Operating; Property; Quality assessment; Other • Adjust list of costs applied to each component • Percentile used as base (before adjustment) for each component • Application of floor or ceiling	Open to consider consolidation of Indirect and Operating Costs
Calculation of property component	• Fair rental value system; Other • Method of calculating per diem component	Additional research and analysis required
Transition period	• None; 1 year; 2 years; 3 years • How calculated	Under Consideration

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POLICY DECISION LIST

CURRENT ASSIGNMENT OF COST TO PER DIEM COMPONENT

Per Diem Component	Types of Costs Included
Direct Care costs	Salaries and wages associated with RNs, LPNs, and CNAs
Indirect Care costs	1. Food/dietary 2. Activities and social services 3. Medical records 4. Central supply room
Operating costs	1. Housekeeping 2. Administration 3. Plant operations 4. Laundry / linen
Split between Indirect Care costs and Operating costs	1. Therapies – PT, OT, Speech 2. Inhalation therapy 3. Parenteral/Enteral (PEN) therapy 4. IV therapy 5. Complex medical equipment and medical supplies 6. Other allowable ancillary costs
Capital / property-related costs	1. Depreciation 2. Interest 3. Taxes 4. Rent 5. Insurance

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FEEDBACK RECEIVED ON IMPLEMENTING A QUALITY INCENTIVE

- Stakeholders across the nursing home industry are receptive to, and believe quality incentives should be incorporated into an updated payment methodology.
- Nursing home providers have expressed concern with introducing new measures that do not align with CMS quality measures.
- Nursing home providers have expressed challenge with responding to the influx of quality initiatives and newly introduced measures that has occurred in recent years.
- Providers are using a mix of additional quality measures, including participation in the Governor's Gold Seal program, resident/caregiver satisfaction surveys, etc.
- AHCA has indicated desire to focus on outcome-oriented quality measures as opposed to process-oriented quality measures.

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OUTCOME ORIENTED VS. PROCESS ORIENTED MEASURES

- **Process-Oriented Measures:** Standardize operational expectations, intended to induce strong clinical outcomes through requiring operational best practices.
- **Outcome-Oriented Measures**: Standardize clinical expectations, focusing less on operational components, and more on patient care outcomes and experience.

Outcome-Oriented	Process-Oriented
CMS Quality Measures (QMs)	Staffing Ratios/Turnover
Resident/Caregiver Satisfaction	Survey Performance/Deficiencies
	Financial Performance
	Project-based Grants/Funding
	Re-balancing Measure

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ELEMENTS OF CURRENT QUALITY MEASUREMENT PROGRAMS

Five Star Quality Rating System (CMS)

- Annual Health Inspection Surveys
- Staffing Ratios
- 17 Long-Stay and Short-Stay Clinical Quality Measures (QMs)
  - 14 QMs are derived from MDS Data
  - 3 QMs are derived from Claims Data (those QMs related to re-admissions in other care settings)

Rating Scale	1 Star	2 Stars	3 Stars	4 Stars	5 Stars	0
Overall Rating	74	134	129	161	159	1
Health Inspection Rating	140	155	155	142	65	1
QM Rating	47	107	121	167	215	1
Staffing Rating	17	41	232	305	59	4
RN Staffing Rating	35	121	233	187	78	4

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STAFFING RATING

- Possible values: 1-5 Stars
- Description: Measures based on nursing home staffing levels: Facility ratings on the staffing domain are based on two measures:
  - 1) Registered nurse (RN) hours per resident day
  - 2) Total staffing hours (RN + licensed practical nurse (LPN) + nurse aide hours) per resident day.
- Note:
  - Other types of nursing home staff such as clerical or housekeeping staff are not included in these staffing numbers.
  - These staffing measures are derived from the CMS Certification and Survey Provider Enhanced Reports (CASPER) system, and are case-mix adjusted based on the distribution of Minimum Data Set, Version 3.0 (MDS 3.0) assessments by Resource utilization groups, version III (RUG-III) group.

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HEALTH INSPECTION RATING

- Possible values: 1-5 Stars
- Description: Measures based on outcomes from State health inspections- Facility ratings for the health inspection domain are based on:
  - Number of deficiencies
  - Scope of deficiencies
  - Severity of deficiencies
- Note:
  - Deficiencies are identified during the three most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations.
  - This measure also takes into account the number of revisits required to ensure that deficiencies identified during the health inspection survey have been corrected.

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CLINICAL QUALITY MEASURES

Long Stay Measures	Short Stay Measures
• Percentage of residents whose need for help with activities of daily living has increased • Percentage of residents whose ability to move independently worsened* • Percentage of high risk residents with pressure ulcers (sores) • Percentage of residents who have/had a catheter inserted and left in their bladder • Percentage of residents who were physically restrained • Percentage of residents with a urinary tract infection • Percentage of residents who self-report moderate to severe pain • Percentage of residents experiencing one or more falls with major injury • Percentage of residents who received an antipsychotic medication	• Percentage of residents whose physical function improves from admission to discharge* • Percentage of residents with pressure ulcers (sores) that are new or worsened • Percentage of residents who self-report moderate to severe pain • Percentage of residents who newly received an antipsychotic medication • Percentage of residents who were re-hospitalized after a nursing home admission* • Percentage of residents who have had an outpatient emergency department visit* • Percentage of residents who were successfully discharged to the community*

*Indicates QM was introduced in July, 2016.

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RELATIONSHIP BETWEEN CMS QUALITY RATINGS AND MDS MEASURES BY FACILITY

	Flu Vaccine	Pneumonia Vaccine	Major Falls	Restraints
Overall Rating	-	0.1171*	-0.1253*	-0.1904*
Health Inspection Rating	0.0856*	0.1155*	-	-
QM Rating	-	-	-0.0781*	-0.2614*
RN Staffing Rating	-	-	-	-
Staffing Rating	-	-	-	-

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RELATIONSHIP BETWEEN CMS QUALITY RATINGS AND MDS MEASURES BY FACILITY

	Self Report – Mod-Sev Pain	Horrible Pain	Pressure Ulcers	Urinary Tract Infections
Overall Rating	-	-	-	-
Health Inspection Rating	-	-	-	-
QM Rating	-	-0.1083*	-	-
RN Staffing Rating				
Staffing Rating	-	-	-	-

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RELATIONSHIP BETWEEN CMS QUALITY RATINGS AND MDS MEASURES BY FACILITY

	Depression (self report)	Depression (staff)	Antipsychotics	Summary
Overall Rating	-0.1071*	-0.1190*	-	-0.1710*
Health Inspection Rating	-	-	-	-0.0934*
QM Rating	-	-0.1025*	-	-
RN Staffing Rating	-	-	-	-
Staffing Rating	-	-	-	-

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GOVERNOR’S GOLD SEAL AWARD COMPONENTS

- Class I or II deficiencies within the last 30 months
- Evidence of financial soundness and stability
- Participation in a consumer satisfaction process
- Evidence of regular involvement of family and friends in facility activity
- Low rate of staff turnover
- No citation for licensure as a result of complaints to the State Ombudsman program within the last 30 months
- Evidence of targeted in-services/training related to quality assurance efforts

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CMS OSCAR/CASPER SURVEY MEASUREMENT OF DEFICIENCIES

Percent of Certified Nursing Facilities with Top Ten Deficiencies - 2014

Location	Infection Control	Accident Environment	Food Sanitation	Quality of Care	Comprehensive Care Plans	Unnecessary Drugs	Qualified Personnel	Clinical Records	Dignity	Pharmacy Consultation
Florida	44%	24%	38%	28%	16%	20%	32%	17%	22%	31%
United States	43%	40%	39%	33%	24%	26%	18%	20%	19%	24%
Rank Among States	27th	45th	27th	28th	37th	33rd	12th	32nd	23rd	14th

Source: http://kff.org/other/state-indicator/percent-of-certified-nursing-facilities-with-top-ten-deficiencies-2014/#

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OTHER QUALITY INCENTIVE OPPORTUNITIES

Project-based Component

- Some states use a grant-like program, where funds are distributed to providers to specifically address defined quality improvement efforts such as:
  - Purchase of equipment for care modernization
  - Physical upgrades that impact resident quality of life
  - Training or in-services

Rebalancing Component

- The state could implement an incentive measure that aligns with MCO's requirements to rebalance the statewide LTSS system, requiring that nursing homes demonstrate a percentage of long-term stay residents able to transition back to community-based settings.

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CONSIDERATIONS FOR QUALITY INCENTIVE

- Which measures do we believe are valuable?
- Will we use all or parts of the two primary methodologies available?(CMS 5-Star and Governor's Gold Seal)
- If we elect to pull specific measures and develop a State-specific quality methodology, how will we weight measures?
- Will we consider requiring providers to conduct additional quality activity, including provision of training/in-service, conducting resident satisfaction surveys, etc.?
- What percent of overall reimbursement will be earmarked for the quality incentive?

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QUESTIONS

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

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- Phone: 850-412-4114

Next Public Meeting scheduled for September 22nd

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THANK YOU