

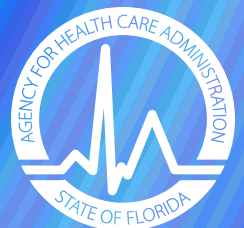
# FLORIDA NURSING HOME PROSPECTIVE PAYMENT

Working Group Recommendations

NOVEMBER  
30

2017

Report and Member Comments Compiled by  
Agency for Health Care Administration



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## **Executive Summary**

In the General Appropriations Act passed by the Legislature during the 2017 legislative session, the Agency for Health Care Administration (the Agency) was directed to convene a working group to review issues related to the transition to a prospective payment system.

“From the funds in Specific Appropriation 217, the Secretary of the Agency for Health Care Administration shall convene a working group to review relevant issues and make recommendations specific to the transition to a prospective payment system for nursing home reimbursement under the Florida Medicaid program. The group shall consist of representatives of nursing home providers and other interested stakeholders. The working group’s focus shall include, but not be limited to: any adjustments needed to existing targets and ceilings applicable to rate calculations; any adjustments needed to existing direct care and indirect care subcomponents; development and refinement of quality measures to be used; the frequency of rebasing under prospective payments; any exemptions from prospective payments; considerations for supplemental payments as part of prospective payments; and a phase-in timeline, if needed, including the need for any transition payments during phase-in. The agency may retain the services of a consultant to assist with the support of this working group. The working group shall submit a report and any recommendations to the agency, the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2017.”  
(Senate Bill 2500, 2017)

This report provides an overview of the working group’s activities and their final recommendations for consideration. With the submission of this report, the working group has completed its objective and will disband.

## **Background**

During the 2016 Legislative Session, legislation passed requiring the Agency to contract with an independent consultant to develop a plan to convert Medicaid payments for nursing home services from a cost based reimbursement methodology to a prospective payment system. The Agency employed Navigant Consulting, Inc. to perform the study and develop the plan. After holding a series of public meetings and stakeholder meetings, the Nursing Facility Payment Method Recommendations Report (Recommendations Report)<sup>1</sup> was submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives on December 30, 2016.

Legislation passed in 2017 to convert Medicaid payments for nursing facility services to a prospective payment system to be effective October 1, 2018. Pertinent excerpts from Section 409.908, Florida Statutes (F.S.) and the Recommendations Report have been included in the appendixes.

## **Purpose**

The purpose of the working group was to review issues relevant to the transition to a prospective payment system, identify areas in which a consensus can be reached by all

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<sup>1</sup> Navigant Consulting, Inc., Nursing Facility Payment Method Recommendations Report. December 29, 2016.  
[http://ahca.myflorida.com/medicaid/Finance/finance/nh\\_rates/docs/Nursing\\_Facility\\_Payment\\_Method\\_Recommendations\\_Report.pdf](http://ahca.myflorida.com/medicaid/Finance/finance/nh_rates/docs/Nursing_Facility_Payment_Method_Recommendations_Report.pdf)

members, and determine recommendations for the Legislature to revisit. These areas of consensus and recommendations must be summarized in a report and submitted to the Agency, the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2017.

**Members**

All working group members were appointed by the Secretary of the Agency for Health Care Administration on August 21, 2017. When choosing appointees, priority was given to individuals whose primary interest, experience, or expertise lay with those who could be directly affected by the new program.

Name	Representing
Robert P. Asztalos	Florida Health Care Association
Erwin P. Bodo	LeadingAge Florida
Martin Casper	Self Employed Nursing Home Consultant
Dale Ewart	1199SEIU, United Healthcare Workers East
Robert Goldstein	Menorah Manor
Scott L. Hopes	CliniLinc, Inc
Jennifer Langer Jacobs	Sunshine Health
Keith A. Myers	MorseLife Health System
Mark Reiner, MD	Catholic Health Services
Beverly Williams	Richards, Mitchell & Company, PA
Jennifer Ziolkowski	Opis Senior Services Group

**Meeting Schedule and Process**

The working group held three meetings between September 26, 2017 and November 13, 2017.

Meeting agendas were created from topics recommended by working group members and the members had open discussion around those topics. Members and Agency staff provided all supporting documentation. Meetings were open for public comments and questions on the specific items on the agenda.

Members were directed to provide written materials to the Agency to compile the final report. If any member did not submit comments on a specific subject it is assumed that the member agrees with current legislation or; if current legislation does not address the criteria, the recommendations as outlined in the Recommendations Report.

## Recommendations

The sections below organize the recommendations by topic and include a general summary. Comments submitted by working group members are included next to the members' names and are copied from their submissions. Members had the opportunity to review and edit their comments in the report prior to the report being finalized. If a member did not submit comments on a particular subject, no information will be included by their name and their support of the legislation or the Recommendations Report is noted in the summary. If a member's comment is in disagreement with a specific topic or the member suggests modification to that topic, that comment is italicized to accentuate the counter viewpoint.

### Development and refinement of quality measures to be used

<b>Quality Measures – General Comments</b>	
The Recommendations Report includes a quality incentive program. Appendix B outlines the components and calculations of the quality incentive model. Ten of the eleven members support the quality incentive model. Several of these members suggested the quality measures should be reviewed in the future to ensure they continue to be appropriate. One member submitted an alternative quality model.	
Robert P. Asztalos Florida Health Care Association	Florida Health Care Association (FHCA) has from the beginning stressed the importance of designing a quality model that is fluid and can be changed as new more impactful quality measures are developed. While working with the legislature these measures were intentionally left out of statutes in order to make them easier to change as necessary.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida strongly supports the Quality Incentive component of a prospective payment system. The basic goal of the quality component should be to financially reward high quality care and to best differentiate the level of quality care provided by Medicaid participating nursing homes. The system designed by Navigant is a good start, but should not stay fixed in stone. Rather as new quality related research results become public the Navigant Quality Matrix should be updated. Additionally, the amount of funds allocated to the Quality Incentive should be increased over time.
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>We have previously submitted an alternative Quality Incentive Payment Pool, attached again here (Appendix H). We believe it has several significant advantages over the proposed Navigant model.</i>  <i>With respect to the Quality Measures in the Navigant model, we have no objection to the measures outlined, but believe that they should be reviewed every two years, and modified as necessary to address statewide quality goals and to reflect facility performance against national benchmarks and new data sets.</i>  <i>Include a Wages and Benefits Incentive to Attract and Retain High Quality Staff. The direct care workforce in nursing homes is often underpaid and lacks comprehensive health insurance. This industry-</i>

	<p><i>side practice leads to many direct care workers taking second jobs, resulting in a tired and overworked workforce with compromised immune systems. Conversely, living wages and 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. This could be included as a quality metric (see Alternative Proposal for FL Quality Incentive Payment Pool Quality Measures, Appendix H) or included in a direct care supplemental payment.</i></p>
Robert Goldstein Menorah Manor	<p>Utilizing the quality measures is an effective way to incentivize providers to improve performance. While perhaps they are not a perfect set of measures, they are a good beginning and should be reviewed annually for appropriateness.</p>
Scott L. Hopes CliniLinc, Inc	<p>I concur with the positions of Members Asztalos (FHCA), Williams and Ziolkowski. Quality metrics should be evaluated following the first 2 years of implementation to determine if modifications need to be made to align incentives with targeted outcome goals of the Agency for the Medicaid population. The quality reimbursement component can and should be used as a tool to continue to move towards including a robust outcome incentive based enhanced reimbursement. The Florida State University System Performance Based Funding Model is an example of the effectiveness of quality incentives creating dramatic change to align state goals, reward excellence and improvement, have clear and simple (measurable) metrics and acknowledge the unique mission of the different institutions. (see <a href="http://www.flbog.edu/board/office/budget/performance_funding.php">www.flbog.edu/board/office/budget/performance_funding.php</a>)</p>
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	<p>In an attempt to recognize that Centers for Medicare and Medicaid Services (CMS) has already studied quality measures for the “Long Stay” nursing home population, it would be appropriate to use these same measures for computing incentives. Since the Navigant model used 6 of the 9 Long Stay processes and outcomes measures identified by CMS, it’s assumed that the 3 measures not used were identified as being problematic or didn’t “...drive quality of care and quality of life for residents”.</p> <p>At this point, eliminating or substituting any of the measures is counterproductive since none of them are perfect. All of the quality measures should be evaluated further in the next 3 or 4 years. Possibly having the measures re-evaluated using the same frequency as rebasing would help providers with predictability of rates. It would also be desirable to have the quality measures evaluated by clinical</p>

	experts with first-hand knowledge of how the measures are reported in the MDS.
Jennifer Ziolkowski Opis Senior Services Group	I think the quality measures as proposed is a good starting point for purposes of defining quality in the new Prospective Payment System (PPS). There may be a need to change some of them in the future but as discussed above those changes should be made for a time period in which the reporting period is not already mostly over.

## Process Measures

<b>Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine</b>	
The influenza vaccine measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 56). Ten of the eleven members support the inclusion of the influenza vaccine measure within the quality model. One of the eleven members would like to eliminate the flu vaccine as a quality measure.	
Robert P. Asztalos Florida Health Care Association	The policy should be to incentivize nursing homes to vaccinate to the maximum capacity. For that reason FHCA supports keeping this quality indicator.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida supports the elimination of Flu Vaccine as a quality measure.</i>  <i>The distribution of Flu Vaccine scores is highly concentrated near 98% and very little "real" differentiation exists among the three percentile thresholds. Elimination of this measure would improve the accuracy of Quality Point assignments.</i>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	1199SEIU supports this measure.
Robert Goldstein Menorah Manor	I support the inclusion of this measure.
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support this measure.  While it is theoretically easy to achieve, the fact that not every nursing home attempts to vaccinate all its residents is an indication of attention to infection control and resident safety/ well-being.



Beverly Williams Richards, Mitchell & Company, PA	I am not opposed to this measure. Further evaluation is recommended in the future.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Percentage of long-stay residents who received an antipsychotic medication</b>	
The antipsychotic medication measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 56). There is consensus among members to use the antipsychotic medication measure within the quality incentive model.	
Robert P. Asztalos Florida Health Care Association	FHCA supports retaining this measure.
Erwin P. Bodo LeadingAge Florida	
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	1199SEIU supports this measure.
Robert Goldstein Menorah Manor	I support the inclusion of this measure.
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support this measure.  There has been significant focus on the usage of antipsychotics on long term care (LTC) residents and great strides have been made in this area. I believe that by including this measure, there will be additional incentives to further decrease the inappropriate use of these medications and thereby benefit the residents.
Beverly Williams Richards, Mitchell & Company, PA	I am not opposed to this measure. Further evaluation is recommended in the future.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Percentage of long-stay residents who were physically restrained</b>	
<p>The restraint measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 57). Seven of the eleven members support the inclusion of the restraint measure within the quality model. Three members support the elimination of restraints from the quality incentive model. One member suggests changing the percentile to receive points for this measure within the model.</p>	
<p>Robert P. Asztalos Florida Health Care Association</p>	<p>In speaking with our Senior Clinicians we believe there is some merit to considering removing the restraints and incontinence measures in the future. Some facilities have an occasional restraint outlier that is needed related to high acuity, medically driven needs, e.g. ventilator facilities that may occasionally have residents attempt de cannulation. I think that eliminating this measure would not create a resumption of use. However, our position has been these changes should be made far enough in the future that any changes take place with an adequate response time for providers to know what they are being measured on for the full reporting period. We would be supportive to making changes but not that impact reporting periods that have already closed.</p>
<p><i>Erwin P. Bodo</i> <i>LeadingAge Florida</i></p>	<p><i>LeadingAge Florida supports the elimination of restraints as a quality measure.</i></p> <p><i>The distribution of Restraints scores is highly concentrated near 0% and all three of the percentile thresholds for points awarded are at 0%. There are no valid reasons for retaining this measure since it does not differentiate nursing home performance in this area and its retention will automatically award 3 points to virtually all participating nursing homes. Conversely, a nursing home with a single incidence of restraints will be in the lowest percentile of the distribution and would not receive any points for this measure. Elimination of this measure would improve the accuracy of Quality Point assignments.</i></p>
<p>Martin Casper Self Employed Nursing Home Consultant</p>	
<p>Dale Ewart 1199SEIU, United Healthcare Workers East</p>	<p>1199SEIU supports this measure.</p>
<p><i>Robert Goldstein</i> <i>Menorah Manor</i></p>	<p><i>I agree to delete this measure and substitute with another, weight loss or pain.</i></p>
<p>Scott L. Hopes CliniLinc, Inc</p>	
<p>Jennifer Langer Jacobs Sunshine Health</p>	
<p><i>Keith A. Myers</i> <i>MorseLife Health System</i></p>	<p><i>Keep "Restraints" as a Quality Measure, but change the percentage allocated.</i></p> <p><i>Rationale – There can be a real need for a restraint, mittens for example for a confused trach patient. A 'Merry Walker' can be a</i></p>

	<i>restraint. The current allocation would mean that one restraint would cause a facility to receive “0” points for this Quality Measure.</i>
<i>Mark Reiner, MD Catholic Health Services</i>	<i>I do not support this measure.  To gain any quality points, a facility must have zero restraints – even in the case where a restraint may indeed be necessary for the safety of the resident. As an example, if a resident has a feeding tube and is constantly trying to pull out the tube, the use of an abdominal binder is reasonable; but if the facility codes this correctly as a restraint, they are penalized. The end result is that many facilities code that they have no restraints, when in fact they are miscoding the MDS in order to achieve “compliance”.  I believe that a significant number of facilities that are identified as having no restraints are in fact miscoded, and therefore this is not a reliable measure.</i>
<i>Beverly Williams Richards, Mitchell &amp; Company, PA</i>	<i>I am not opposed to this measure. Further evaluation is recommended in the future.</i>
<i>Jennifer Ziolkowski Opis Senior Services Group</i>	

## Outcome Measures

<b>Percentage of long-stay residents with a urinary tract infection</b>	
The urinary tract infection (UTI) measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 57). There is consensus among members to use the UTI measure within the quality incentive model.	
<i>Robert P. Asztalos Florida Health Care Association</i>	<i>FHCA supports retaining this measure.</i>
<i>Erwin P. Bodo LeadingAge Florida</i>	
<i>Martin Casper Self Employed Nursing Home Consultant</i>	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>1199SEIU supports this measure.</i>
<i>Robert Goldstein Menorah Manor</i>	<i>I support the inclusion of this measure.</i>
<i>Scott L. Hopes CliniLinc, Inc</i>	<i>I support the continued inclusion of this measure.</i>
<i>Jennifer Langer Jacobs Sunshine Health</i>	

Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support the use of this measure.  This is a reasonable parameter to measure – facilities with high numbers of urinary tract infections (UTI) may indeed have issues with certain aspects of patient care and need to strive for improvement.
Beverly Williams Richards, Mitchell & Company, PA	I agree with this measure.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Percentage of high risk long-stay residents with pressure ulcers</b>	
The pressure ulcers measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 57). Ten of the eleven members support the inclusion of the pressure ulcers measure within the quality model. One of the eleven members supports the inclusion of this measure with a modification.	
Robert P. Asztalos Florida Health Care Association	FHCA supports retaining this measure.
Erwin P. Bodo LeadingAge Florida	
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	1199SEIU supports this measure.
Robert Goldstein Menorah Manor	I support the inclusion of this measure.
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	<i>I support measuring Pressure Ulcers acquired in house.  While I believe that pressure ulcers are an indication of quality of care, this measure fails to distinguish between residents who were admitted to a facility with wounds and those who acquired the wounds while a resident. It would be better if the measure was that of residents who</i>

	<i>have newly developed pressure ulcers or whose ulcers have worsened. CMS does gather this information in the minimum data set (MDS), but it is not currently reported with the Nursing Home Compare reports.</i>
Beverly Williams Richards, Mitchell & Company, PA	I agree with this measure.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Percentage of long-stay residents experiencing one or more falls with major injury</b>	
The falls with major injury measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 58). There is consensus among members to use the falls with major injury measure within the quality incentive model.	
Robert P. Asztalos Florida Health Care Association	FHCA supports retaining this measure.
Erwin P. Bodo LeadingAge Florida	
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	1199SEIU supports this measure.
Robert Goldstein Menorah Manor	I support the inclusion of this measure.
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support the use of this measure.
Beverly Williams Richards, Mitchell & Company, PA	I agree with this measure.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Percentage of low risk long-stay residents who lose control of their bowels or bladder</b>
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<p>The incontinence measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 58). Seven of the eleven members support the inclusion of the incontinence measure within the quality model. Two of the members who support inclusion recommend reviewing this measure for elimination in the future. Three of the members recommend eliminating the incontinence measure for the quality incentive model. One member is neutral on this measure.</p>	
<p>Robert P. Asztalos Florida Health Care Association</p>	<p>FHCA believes that this indicator can be eliminated at a future date. Often patients lack awareness of the need to toilet and motivation to do so. With the concepts of person centered care we cannot, in these situations, force the issue without potentially catastrophic behavioral reactions.</p>
<p>Erwin P. Bodo LeadingAge Florida</p>	<p>The distribution of incontinence scores is wide enough to ensure that percentile thresholds for points awarded are well spaced. There is no statistical reason for eliminating this measure. As discussed during the first two meetings there may be other legitimate concerns with the use of this measure in the Quality Matrix. Elimination of this measure may or may not improve the accuracy of Quality Point assignments.</p> <p>LeadingAge Florida is neutral on this issue.</p>
<p>Martin Casper Self Employed Nursing Home Consultant</p>	
<p>Dale Ewart 1199SEIU, United Healthcare Workers East</p>	<p>1199SEIU supports this measure.</p>
<p><i>Robert Goldstein Menorah Manor</i></p>	<p><i>I agree to delete this measure, It is currently not included in the CMS 5 Star Quality Measure Rating.</i></p>
<p>Scott L. Hopes CliniLinc, Inc</p>	
<p>Jennifer Langer Jacobs Sunshine Health</p>	
<p><i>Keith A. Myers MorseLife Health System</i></p>	<p><i>Eliminate "Incontinence" from the Quality Measures.</i></p> <p><i>Rationale - The National Quality Forum no longer considers incontinence as a measure of quality. Incontinence is most often related to physical functioning, cognitive decline and dementia.</i></p>
<p><i>Mark Reiner, MD Catholic Health Services</i></p>	<p><i>I do not support this measure.</i></p> <p><i>By the very nature of the residents who reside in nursing homes (high rate of dementia), they are either incontinent or have great risk of becoming incontinent. Once they reach this point, there is very little that a facility can do to reverse this. To penalize a facility that has a preponderance of complex patients makes no sense – if anything they need more resources, not less.</i></p>
<p>Beverly Williams Richards, Mitchell &amp; Company, PA</p>	<p>I am not opposed to this measure initially, but recommend that it be reconsidered in the future to address concerns regarding dementia.</p>

Jennifer Ziolkowski Opis Senior Services Group	
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<b>Percentage of long-stay residents whose need for help with daily activities has increased</b>	
The activities of daily living (ADL) measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 58). There is consensus among members to use the activities of daily living component within the quality incentive model.	
Robert P. Asztalos Florida Health Care Association	FHCA supports retaining this measure.
Erwin P. Bodo LeadingAge Florida	
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	1199SEIU supports this measure.
Robert Goldstein Menorah Manor	I support the inclusion of this measure.
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support this measure.
Beverly Williams Richards, Mitchell & Company, PA	I agree with this measure.
Jennifer Ziolkowski Opis Senior Services Group	

### Structure Measures

<b>Hours of licensed nursing (RN, LPN) and CNA staffing</b>
The staffing measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 59). Six of the eleven members support the inclusion of the staffing measure within the quality model. Three members recommended calculating the

staffing quality measure at a higher value. One member would like to use a different data source to calculate this measure. One member is neutral on this issue.	
Robert P. Aszталos Florida Health Care Association	FHCA supports this measure as currently proposed.
Erwin P. Bodo LeadingAge Florida	Calculating Register Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA) staff at a higher value than Social Work and Activity staff may be reasonable. Without additional data and research relating to the importance of these two types of workers to the quality of life and quality of care of nursing home residents, LeadingAge Florida must remain neutral on this issue.
<i>Martin Casper Self Employed Nursing Home Consultant</i>	<i>I believe it is important to ensure that the nursing staffing matrix uses the 'Resource Utilization Group (RUG) adjusted' matrix utilized by CMS Nursing Home Compare rather than an unweighted average in determining percentiles.</i>
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>Direct Care Staffing should earn the full six points. If other positions are included (for example, Social Work and Activity Staff), those points should shift from another element of the matrix and should not exceed three points.</i>  <i>We suggest transitioning to Payroll Based Journaling (PBJ) data as soon as it becomes available. The state should continue to review its staffing data collection in order to adequately address the fundamental role staffing plays in a resident's daily experience.</i>
<i>Robert Goldstein Menorah Manor</i>	<i>I support the inclusion of this measure. I would reallocate the points to more heavily weight this measure with 4 points.</i>
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
<i>Keith A. Myers MorseLife Health System</i>	<i>Reallocate the 3 points which were associated with "Incontinence" to "Combined Direct Care Staffing" giving that specific Structure Measure a total possible 6 points; with Activities and Social work remaining at 3 points.</i>
Mark Reiner, MD Catholic Health Services	I support this measure.  I recommend using the PBJ data that CMS will release starting in January, 2018 as this will more accurately reflect the staffing of facilities.
Beverly Williams Richards, Mitchell & Company, PA	I agree with this measure. Recommend that PBJ data be used when available since it should be more up-to-date than using Medicaid cost report data.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Employees of social work and activities staff</b>
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<p>The social work and activities staff measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 59). Nine of the eleven members support the inclusion of the social work and activities staff measure within the quality model. Two members recommended calculating the measure at a lower value.</p>	
<p>Robert P. Asztalos Florida Health Care Association</p>	<p>With the increased importance and significance of the Social Work and Activity staff in Quality of life and person centered care, providing these positions with equivalent points would incentivize a facility to add more support to these areas that are often spread thin. I believe the benefit of having increased availability of non-nursing staff that can therapeutically address challenging behaviors and issues such as mood state, depression, anxiety, falls, pain, etc. through alternatives to medication is an under recognized benefit. FHCA supports this measure as proposed but would be open to changing it to a staff retention measure down the road as discussed previously by the Agency for Health Care Administration (AHCA)/Navigant.</p>
<p>Erwin P. Bodo LeadingAge Florida</p>	
<p>Martin Casper Self Employed Nursing Home Consultant</p>	
<p><i>Dale Ewart 1199SEIU, United Healthcare Workers East</i></p>	<p><i>1199SEIU does not support giving equal weight to direct hands-on staff (RNs, LPNs, CNAs) and Social Work and Activities staff. As noted above, we support reallocating these quality points to the licensed nursing and CNA measure.</i></p>
<p><i>Robert Goldstein Menorah Manor</i></p>	<p><i>I support the inclusion of this measure. I would reallocate the points down to 2.</i></p>
<p>Scott L. Hopes CliniLinc, Inc</p>	
<p>Jennifer Langer Jacobs Sunshine Health</p>	
<p>Keith A. Myers MorseLife Health System</p>	
<p>Mark Reiner, MD Catholic Health Services</p>	<p>I support this measure.</p>
<p>Beverly Williams Richards, Mitchell &amp; Company, PA</p>	<p>I agree with this measure.</p>
<p>Jennifer Ziolkowski Opis Senior Services Group</p>	

**Credentials**

<p><b>CMS 5 Star Rating</b></p>
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<p>The CMS 5 Star Rating measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 59). Nine of the eleven members support the inclusion of the CMS 5 Star Rating measure within the quality model. One member believes this measure deserves further study. One member recommends eliminating the CMS overall 5 Star Rating and use only the quality portion of the CMS 5 Star Rating.</p>	
<p>Robert P. Asztalos Florida Health Care Association</p>	<p><i>FHCA believes this proposal deserves further study.</i></p>
<p>Erwin P. Bodo LeadingAge Florida</p>	<p>LeadingAge Florida strongly opposes the elimination of this measure from the Quality Matrix.</p> <p>The CMS 5 Star measure is supported by more research than any other quality related measure. It is based on the work of a group of highly respected researchers and has been vetted by the federal government for measuring quality in nursing homes.</p>
<p>Martin Casper Self Employed Nursing Home Consultant</p>	
<p>Dale Ewart 1199SEIU, United Healthcare Workers East</p>	<p>The only credential for which points should be awarded is the CMS 5 Star Rating.</p>
<p>Robert Goldstein Menorah Manor</p>	<p>I support inclusion of this measure. It is nationally recognized by the nursing home field. I support including the overall 5 Star rating measure which contains components of survey, staffing and quality.</p>
<p>Scott L. Hopes CliniLinc, Inc</p>	
<p>Jennifer Langer Jacobs Sunshine Health</p>	
<p>Keith A. Myers MorseLife Health System</p>	
<p>Mark Reiner, MD Catholic Health Services</p>	<p><i>I support this measure using only the Quality Portion.</i></p> <p><i>If we are wishing to reward quality, then we should only use the quality portion of this measure, as opposed to the composite one.</i></p>
<p>Beverly Williams Richards, Mitchell &amp; Company, PA</p>	<p>I agree with using the CMS overall rating which takes health inspection results into consideration.</p>
<p>Jennifer Ziolkowski Opis Senior Services Group</p>	

**Nursing Home Gold Seal Award**

The Nursing Home Gold Seal Award measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 60). Eight of the eleven members support the inclusion of the Nursing Home Gold Seal Award measure within the quality model. Two

members recommended eliminating credentialing points for providers with a CMS 5 Star Quality Rating below three stars. One member recommends eliminating this measure from the quality model.	
Robert P. Asztalos Florida Health Care Association	FHCA strongly opposes the idea to eliminate credentialing points for providers below three stars. The reason for this quality program is to give all nursing homes an incentive to improve. We should encourage all nursing homes to seek quality awards or Joint Commission accreditation. Additionally, because of the structure of the star system, a facility could drop a star not because of a change in its care, but because other nursing homes around them changed.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>Eliminate credentialing points for facilities if they have under three stars in the CMS Five-Star Quality Rating System. LeadingAge Florida supports this change.</i>  <i>Awarding 5 points for credentialing to a nursing home with three or fewer CMS Quality Rating Stars would raise significant questions regarding the reasonableness of the Quality Matrix point system. LeadingAge Florida anticipates that implementation of this recommendation would improve the scoring system and would negatively impact only a very few facilities.</i>
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>The only credential for which points should be awarded is the CMS Star Rating. We have commented at length on this previously (September 22, 2016). We prefer that no secondary rating measurements be used for quality reimbursement incentives, but the CMS rating closely tracks the same quality indicators as the proposed methodology. We believe it is inappropriate to outsource quality ratings and reimbursement decisions to private organizations, whose methodology may not be transparent and who are not subject to democratic accountability. Awarding a significant number of quality points from credentialing organizations has the effect of heavily weighting a huge portion of the quality incentive payment on secondary sources rather than using federally accepted standards for quality care. This is not good public policy.</i>
<i>Robert Goldstein Menorah Manor</i>	<i>I support the inclusion of this measure and agree to only awarding points if a Home has an overall CMS rating of 3 stars or more.</i>
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support this measure.

Beverly Williams Richards, Mitchell & Company, PA	I agree with using Nursing Home Gold Seal as a credential regardless of what the CMS Five-Star Quality Rating is. The low incidence of facilities awarded the Gold Seal with less than 3 stars on the Five-Star Quality Rating could be indicative of problems or errors within the Five-Star rating.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Joint Commission Accreditation</b>	
The Joint Commission Accreditation measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 61). Seven of the eleven members support the inclusion of the Joint Commission Accreditation measure within the quality model. Three members recommended eliminating credentialing points for providers with a CMS 5 Star Quality Rating below three stars. One member recommends eliminating this measure from the quality model.	
Robert P. Asztalos Florida Health Care Association	FHCA strongly opposes the idea to eliminate credentialing points for providers below three stars. FHCA does not support this idea. The Joint Commission is a well-established organization with a respected process for accreditation.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida supports this proposed change.  Awarding 5 points for credentialing to a nursing home with three or fewer CMS Quality Rating Stars would raise significant questions regarding the reasonableness of the Quality Matrix point system. LeadingAge Florida anticipates that implementation of this recommendation would improve the scoring system and likely would negatively impact only a very few facilities.</i>
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>The only credential for which points should be awarded is the CMS Star Rating. We have commented at length on this previously (September 22, 2016). We prefer that no secondary rating measurements be used for quality reimbursement incentives, but the CMS rating closely tracks the same quality indicators as the proposed methodology. We believe it is inappropriate to outsource quality ratings and reimbursement decisions to private organizations, whose methodology may not be transparent and who are not subject to democratic accountability.</i>
<i>Robert Goldstein Menorah Manor</i>	<i>I support the inclusion of this measure and agree to only awarding points if a Home has an overall CMS rating of 3 stars or more.</i>
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
<i>Keith A. Myers MorseLife Health System</i>	<i>Eliminate the five (5) points for credentialing (Joint Commission Accreditation or the AHCA National Quality Award) unless the nursing home has at least a 3 Star overall rating from CMS.</i>

Mark Reiner, MD Catholic Health Services	I support this measure.
Beverly Williams Richards, Mitchell & Company, PA	I agree with using Joint Commission Accreditation as a credential regardless of what the CMS Five-Star Quality Rating is.
Jennifer Ziolkowski Opis Senior Services Group	

<b>AHCA National Quality Award</b>	
The AHCA National Quality Award measure is proposed in the quality incentive model of the Recommendations Report (Appendix B, page 62). Eight of the eleven members support the inclusion of the AHCA National Quality Award measure within the quality model. Two members recommended eliminating credentialing points for providers with a CMS 5 Star Quality Rating below three stars. One member recommends eliminating this measure from the quality model.	
Robert P. Asztalos Florida Health Care Association	FHCA strongly opposes the idea to eliminate credentialing points for providers below three stars. FHCA does not support this idea. The AHCA gold and silver awards are based on the Malcolm Baldrige National Quality Award Standards. These are recognized standards for measuring quality. Instead of seeking to restrict quality improvement awards, we should be encouraging more awards and accreditation processes for nursing homes to improve.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida supports this proposed change.  Awarding 5 points for credentialing to a nursing home with three or fewer CMS Quality Rating Stars would raise significant questions regarding the reasonableness of the Quality Matrix point system. LeadingAge Florida anticipates that implementation of this recommendation would improve the scoring system and likely would negatively impact only a very few facilities.</i>
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>The only credential for which points should be awarded is the CMS Star Rating. We have commented at length on this previously (September 22, 2016). We prefer that no secondary rating measurements be used for quality reimbursement incentives, but the CMS rating closely tracks the same quality indicators as the proposed methodology. We believe it is inappropriate to outsource quality ratings and reimbursement decisions to private organizations, whose methodology may not be transparent and who are not subject to democratic accountability.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs	

Sunshine Health	
<i>Keith A. Myers MorseLife Health System</i>	<i>Eliminate the five (5) points for credentialing (Joint Commission Accreditation or the AHCA National Quality Award) unless the nursing home has at least a 3 Star overall rating from CMS.</i>
Mark Reiner, MD Catholic Health Services	I support this measure.
Beverly Williams Richards, Mitchell & Company, PA	I agree with using AHCA National Quality Award as a credential regardless of what the CMS Five-Star Quality Rating is.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Threshold to receive quality incentive payment</b>	
Section 409.908(2)(b)1.f., F.S. (Appendix A) requires the threshold to qualify for the quality incentive payment to be the 20 <sup>th</sup> percentile of included facilities. Ten of the eleven members support the current threshold in legislation. One member would like to eliminate the threshold to receive quality points for year-to-year improvement and increase the threshold to receive all other points to 30%.	
Robert P. Asztalos Florida Health Care Association	FHCA supports leaving the threshold at the 20th percentile as passed by the Florida Legislature.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>Exempt quality points earned for year to year improvement from the threshold and increase the threshold to the 30th percentile. LeadingAge Florida supports this proposed change.</i>  <i>LeadingAge Florida made this proposed change and remains supportive of its implementation.</i>  <i>The Quality Matrix awards points for measurable year-to-year improvement for several quality measures, but also imposes a 20<sup>th</sup> percentile threshold of points earned for allocating Quality Incentive funds. Most year-to-year improvement points earned occur in lower quality facilities with low quality point scores. Subjecting improvement points earned to the 20<sup>th</sup> percentile threshold would preclude providing Quality Incentive payments for year-to-year improvements. The proposed change would ameliorate this inequity.</i>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	

Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I support leaving the threshold at 20% as currently in Statute to encourage more facilities to make changes that impact quality of care.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Existing direct care and indirect care subcomponents</b>	
Section 409.908(2)(b)2.-3., F.S. (Appendix A) outlines the cost centers included in the direct and indirect care subcomponents used in the prospective payment system. Ten of eleven members support the current cost centers in legislation. One member would like to move housekeeping and laundry from the Operating component to the Indirect component. One member did not address issues with the direct and indirect care subcomponents, but recommended adjustments to the current peer groups.	
Robert P. Aszталos Florida Health Care Association	In the PPS passed by the legislature costs that have the greatest impact on resident quality of life must be included in the Direct Care component; costs with a strong impact are included in the Indirect Care component; and costs with less of an impact on resident quality of life are mapped to the Operating component. Most of the current cost mapping already meets these goals; however, changes were needed that included moving: a) all therapy and dietary costs to Direct Care; b) complex medical equipment, medical supplies and other allowable ancillary cost centers to Indirect Care, and c) medical records to the Operating component. These changes have already been made and there is not a need to make any additional changes.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida recommends retaining the three geographic classes of the current reimbursement plan and superimposing a facility size grouping similar to that in the current reimbursement plan. (In LeadingAge Florida analyses 80 beds created the most statistically significant break point.) LeadingAge Florida also recommends that every five years, the peer group definitions be reexamined to determine if changes in economic circumstances would necessitate realignment of the groups.  During the October PPS working group meeting members were asked to provide suggestions regarding thresholds for peer-group adjustments. We are limiting this discussion to geographic and size peer groups. There are two reasonable approaches to creating peer groups: 1. Using external economic indicators and 2. Using actual

	<p>economic data from the population for which peer groups are desired. The Navigant study, on page 19 observes:</p> <p>“if measureable and justifiable cost differences exist for some facilities, then separate groupings based on these cost differences will allow for a more fair distribution of Medicaid funds.”</p> <p>Based on regression analysis using nursing home cost report data, Navigant recommended two geographic peer groups. The South Group would consist of AHCA Districts 10 and 11, and all other areas of the state would be classified into the North Group. Subsequent to the release of the Navigant Study, LeadingAge Florida conducted its own geographic grouping regression analyses and concluded that a South Group defined as AHCA Districts 8, 9, 10, and 11 has statistically better predictive strength than the Navigant defined South Group. In fact, the current geographic peer grouping of North, Central, and South regions also has more predictive strength than the geographic peer group definition proposed by Navigant. During the 2017 Legislative Session, the Appropriations Bill established the South Group as AHCA Districts 10 and 11, and Palm Beach and Okeechobee Counties. The revised South Group was not based on economic analysis, but has a better fit to existing data than the Navigant-designed grouping.</p> <p>Contrary to some comments made during the October working group meeting, a 2015 University of South Florida prospective plan study also used the North, Central, and South regions and the size groupings as defined in the current reimbursement plan.</p> <p>Well defined smaller numbers of peer groups always lead to greater disparity between current and proposed payment rates and unnecessarily excessive gains and losses. Larger numbers of peer groups reduce losses and gains, but also reduce efficiency incentives. Using actual nursing home cost data typically fits cost inflation best, since it reflects current payment standards and limitations.</p> <p>Ideally, LeadingAge Florida would like to see geographic peer groups defined by an external economic index, such as the Florida Price Level Index, or the Labor and Wage Index used by the federal government in the Medicare PPS system.</p> <p>The September 1, 2017 Medicaid rate setting database contains 658 nursing homes with a number of beds ranging from a low of 20 to a high of 438. Nursing home fixed costs are definitely subject to economies of scale. The lack of facility size peer grouping disadvantages small nursing homes and creates unacceptable gains for larger facilities.</p>
<p>Martin Casper Self Employed Nursing Home Consultant</p>	



Dale Ewart 1199SEIU, United Healthcare Workers East	<i>Move housekeeping and laundry costs from Operating to Indirect Care Component. Housekeeping and laundry staff have an important role in infection prevention and control, which is a key priority as antibiotic resistant infections are becoming more prevalent and can lead to costly hospitalizations and even premature resident deaths.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support the proposed methodology.  The outlined per diem components, median cost percentages and floor percentages are all acceptable. In addition, the assignment/ reassignment of various cost categories to each component is reasonable.
Beverly Williams Richards, Mitchell & Company, PA	The cost centers contained in the direct care and indirect care components in Statute appear to be accurate.
Jennifer Ziolkowski Opis Senior Services Group	There is no need to make any changes to this component. The legislature moved the appropriate cost components to the category based on the higher ceilings for items most important to resident quality of life.

<b>Use the most recent data available to calculate the median rates for the direct and indirect care components</b>	
Section 409.908(2)(b)1.b., F.S. (Appendix A) requires the September 2016 cost reports to be used to calculate the median costs. Eight of eleven members support the median rate calculations in legislation. Three members recommend using the September 2017 cost reports in the median calculations.	
Robert P. Asztalos Florida Health Care Association	By using the 2016 rates in 2018, \$37 million of provider assessment rate increase is freed up to use for transition payments that hold facilities harmless to losses. Using 2017 rates would retain that \$37 million in the base, not make it available for transition payments, and jeopardize the three year hold harmless provision that was an important part of getting industry consensus behind the legislatures PPS proposal.
Erwin P. Bodo LeadingAge Florida	<i>LeadingAge strongly supports the use of the September 1, 2017 rates as the base rate for PPS hold harmless.</i>  <i>Approximately 73% of the Medicaid participating nursing homes received September 1, 2017 rates higher than their September 2016 rates. Reductions in the September 1, 2017 rates occurred due to settlement of interim rates, filing full year cost reports, or as a result of audit adjustments. In the overwhelming majority of the reductions, the</i>

	<p><i>September 1, 2017 rates more accurately reflect actual cost of operations. To use the September 1, 2016 rates as the basis for PPS hold-harmless calculations would unnecessarily and unreasonably harm nearly three fourths of the homes and at the same time reward some facilities with excessive windfall profits.</i></p> <p><i>The argument stated during the October meeting that the September 1, 2016 rates are necessary to allow the hold-harmless provision during the first three years of the PPS is without merit. Most of the funds required for the hold-harmless were the result of increased revenues generated by the Quality Assessment. The remaining funds came from a small amount of general revenue and transferring money from the lease bond related trust fund. The trust fund remains available if the September 1, 2017 rates are used and with the economy booming, it is very likely that the Quality Assessment will generate more dollars this coming year than last year. The time frame for quality measure data is specified as the latest available as of May 31 of the year in which the rate period begins. Similarly, the fair rental value system will use the data from the most recent FRVS survey, which will be conducted later this year or in early 2018.</i></p>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
<i>Robert Goldstein Menorah Manor</i>	<i>I support the use of the September 1, 2017 rates as the base rate for PPS. For the majority of Homes these rates are higher and more accurately reflect current operations.</i>
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
<i>Mark Reiner, MD Catholic Health Services</i>	<p><i>I recommend use of 2017 data.</i></p> <p><i>It seems logical to me that the most recent data that is currently available should be used to set the prospective payment rates as outline in the legislation for 2018 forward.</i></p>
Beverly Williams Richards, Mitchell & Company, PA	The underlying premise of PPS is to use historical audited data which will be presumed to be 3-4 years old when used. I support using September 2016 data although using cost settled data for this period would be recommended.
Jennifer Ziolkowski	

Opis Senior Services Group	
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<p><b>Adjustments needed to existing targets and ceilings applicable to rate calculations</b>  Section 409.908(2)(b)1.a.-c. (Appendix A) details the existing targets and ceilings applicable to rate calculations. Nine of eleven members support the targets and ceilings in legislation. One member recommends changes to the peer groups. One member recommends changes to the floors and the medians.</p>	
Robert P. Asztalos Florida Health Care Association	We believe that the specified threshold in the system passed by the legislature (“Floor”) guards against creating incentives that jeopardize the quality care delivered and limits extreme financial gains. The Floors as currently set will ensure funding is used to enhance quality through the Direct and Indirect Care rate components and no change is needed.
Erwin P. Bodo LeadingAge Florida	<p><i>LeadingAge Florida recommends retaining the three geographic classes of the current reimbursement plan and superimposing a facility size grouping similar to that in the current reimbursement plan. (In LeadingAge Florida analyses, 80 beds created the most statistically significant break point.) LeadingAge Florida also recommends that every five years, the peer group definitions be reexamined to determine if changes in economic circumstances would necessitate realignment of the groups.</i></p> <p><i>There are two reasonable approaches to creating peer groups: 1. Using external economic indicators and 2. Using actual economic data from the population for which peer groups are desired. The Navigant study, on page 19 observes:</i></p> <p><i>“if measureable and justifiable cost differences exist for some facilities, then separate groupings based on these cost differences will allow for a more fair distribution of Medicaid funds.”</i></p> <p><i>Based on regression analysis using nursing home cost report data, Navigant recommended two geographic peer groups. The South Group would consist of AHCA Districts 10 and 11, and all other areas of the state would be classified into the North Group. Subsequent to the release of the Navigant Study, LeadingAge Florida conducted its own geographic grouping regression analyses and concluded that a South Group defined as AHCA Districts 8, 9, 10, and 11 has statistically better predictive strength than the Navigant defined South Group. In fact, the current geographic peer grouping of North, Central, and South regions also has more predictive strength than the geographic peer group definition proposed by Navigant. During the 2017 Legislative Session, the Appropriations Bill established the South Group as AHCA Districts 10 and 11, and Palm Beach and Okeechobee Counties. The revised South Group was not based on economic analysis, but has a better fit to existing data than the Navigant-designed grouping.</i></p> <p><i>Contrary to some comments made during the October working group meeting, a 2015 University of South Florida prospective plan study also</i></p>

	<p><i>used the North, Central, and South regions and the size groupings as defined in the current reimbursement plan.</i></p> <p><i>Well defined smaller numbers of peer groups always lead to greater disparity between current and proposed payment rates and unnecessarily excessive gains and losses. Larger numbers of peer groups reduce losses and gains, but also reduce efficiency incentives. Using actual nursing home cost data typically fits cost inflation best, since it reflects current payment standards and limitations.</i></p> <p><i>Ideally, LeadingAge Florida would like to see geographic peer groups defined by an external economic index, such as the Florida Price Level Index, or the Labor and Wage Index used by the federal government in the Medicare PPS system.</i></p> <p><i>The September 1, 2017 Medicaid rate setting database contains 658 nursing homes with a number of beds ranging from a low of 20 to a high of 438. Nursing home fixed costs are definitely subject to economies of scale. The lack of facility size peer groupings disadvantages small nursing homes and creates unacceptable gains for larger facilities.</i></p>
<p><i>Martin Casper Self Employed Nursing Home Consultant</i></p>	
<p><i>Dale Ewart 1199SEIU, United Healthcare Workers East</i></p>	<p><i>We recommend that the Legislature significantly revises the payment of direct care costs from a median cost to a percentile cap based on costs in each class of facility.</i></p> <ul style="list-style-type: none"> <li><i>• Reimburse Direct Care Cost Centers up to a percentile of the provider's peer group. Rather than reimburse providers with a direct care component payment that ranges from 95% ("floor") to 100% ("ceiling") of the median, Florida should reimburse providers in a prospective manner the lower of their costs of the 90<sup>th</sup> percentile ("ceiling") in their peer group for direct care costs. This addresses both concerns about leveling of rates and restricting future improvements in quality and quantity of hands-on caregivers.</i></li> </ul> <p><i>If moving to a percentile-based direct care reimbursement model is not adopted, there are some adjustments which should be made to the Navigant model which would be ameliorate, but not fully fix our concerns:</i></p> <ul style="list-style-type: none"> <li><i>• For Direct Care Cost Centers, use a percentage of the median, but increase the "ceiling" to 135% of median costs. Remove the "floor" entirely. Nursing home operators whose direct care costs are below the median could always increase their costs and be fully reimbursed up to 135% of the median, but the dollars would</i></li> </ul>

	<i>be tied to facility decisions, not awarded in the expectation that those providers would do the right thing.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	Current legislation should be maintained for first three years.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	I support the proposed methodology.  The outlined per diem components, median cost percentages and floor percentages are all acceptable. In addition, the assignment/ reassignment of various cost categories to each component is reasonable.
Beverly Williams Richards, Mitchell & Company, PA	The Floors and Ceilings as outlined in Statute will accomplish the goals of rewarding efficiency in the operating component and make sure providers spend at a sufficient rate to support quality in the direct and indirect components. Peer grouping, as reported by Navigant, included a listing of CMS wage indices as well as a listing of Florida Price Level Index values for areas and counties in Florida. The counties with the highest wages and the highest price levels are not necessarily the same. Possibly looking into using both indices is recommended for future years.
Jennifer Ziolkowski Opis Senior Services Group	This should remain unchanged. The floors are set in a manner to ensure providers continue to spend on patient care or see a reduction in their rate.

<b>Considerations for supplemental payments as part of prospective payments related to ventilators</b>	
Section 409.908(2)(b)1.h., F.S. (Appendix A) requires a ventilator supplemental payment of \$200 per Medicaid day. All members support the supplemental payment for ventilators. However, three members have concerns about the limitation on the number of patients to receive the supplemental payment.	
Robert P. Asztalos Florida Health Care Association	FHCA fully supports both supplemental payments created by the legislation. There has been a real need in Florida to adequately reimburse nursing facilities for providing care to ventilator dependent patients for several years and this add-on will go a long way to addressing the need. FHCA feels it is important that AHCA ensure that the appropriate policies and procedures are in place to ensure that centers are providing the necessary services to receive this limited add-on. FHCA discussed several other additional add-ons and feel there may be a need to address in the future but should only do so if there is additional funding to cover them.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida supports supplemental payments for ventilator care.

<p>Martin Casper Self Employed Nursing Home Consultant</p>	<ul style="list-style-type: none"> <li>• As set up by the legislation, there will be a maximum of 110 Medicaid ventilator dependent patient slots available to be reimbursed at the \$200 per day differential per patient day effective October 1, 2018.</li> <li>• Facilities must apply for acceptance into the 'Specialized Care Program' to be eligible to receive this differential by meeting the following criteria:             <ol style="list-style-type: none"> <li>1. 24/7/365 respiratory therapist in house staffing on an 8:1 ventilator patient to respiratory therapist ratio. A 9:1 ratio will be permitted for no more than 3 consecutive days.</li> <li>2. A physician visit to each ventilator dependent patient at least weekly once the patient is accepted to receive the differential. The attending physician may utilize his/her extender alternate weeks as long as that extender is working on an Agreement with that physician. A pulmonologist or his extender must visit the patient at least monthly.</li> <li>3. RN in house coverage 24/7/365 for at least 97% of the time.</li> <li>4. Completing an application to the State certifying they are in compliance with the above 3 requirements and will be expected to be in compliance at all times. The State will need to approve each application</li> </ol> </li> <li>• As soon as possible, all facilities will be asked for a list of any Medicaid reimbursed ventilator dependent patients they currently have in their facilities (bi-pap and c-pap patients are not included) and the day they became ventilator dependent in THEIR facility. (In the event the patient list is greater than 110, priority will be given to the earliest nursing home ventilator dependent patient). This list will include the current Medicaid Managed Care Plan paying for the patient.</li> <li>• Once the list is established, it will be maintained at the State and updated going forward. Facilities accepted to the program will be advised that in order to maintain this acceptance, they must update any and all status changes to patients on this list. New potential ventilator dependent admissions will be sent to the State utilizing a form to be developed and will be accepted or rejected for inclusion to the program or the 'waiting list' should all slots be filled.</li> <li>• Thought may be given to have the add-on reimbursement for this program to be directly paid to the facility by the State rather than the Medicaid Managed Care companies since it is a limited program.</li> </ul>
<p>Dale Ewart 1199SEIU, United Healthcare Workers East</p>	<p><i>We support a \$200 supplemental payment for ventilator care, provided standards are created for providers wishing to provide this service. We are concerned about placing a cap on the number of Medicaid days, and would urge the Legislature to appropriate new money to fund the supplement without an arbitrary limit.</i></p>
<p>Robert Goldstein Menorah Manor</p>	

Scott L. Hopes CliniLinc, Inc	<i>The current supplements are appropriate but, the caps placed should be evaluated to determine if the supplemental payment will result in increased availability of ventilator beds in LTC facilities to allow for earlier discharge from acute care hospital setting. If this is realized, the state should take advantage of shifting the funding from the acute care hospital budget to the lower cost long term care supplemental providers to realize the savings.</i>
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	<i>I support this measure.  This is actually long overdue. It might be wise to see if the Agency (AHCA) can determine how many patients remain in acute care hospitals because of inability to place – and at what cost to the state. Based on this information, they may want to propose expanding the number of slots above to 110 as this may very well save the state additional monies.</i>
Beverly Williams Richards, Mitchell & Company, PA	I am in support of the supplemental payment for ventilators and understand the need to cap the number of Medicaid days.
Jennifer Ziolkowski Opis Senior Services Group	The current ventilator supplement payment is a great idea but there is need for significant administrative work on the part of AHCA to make it work. There is a need to truly understand how many ventilator patients exist in nursing homes currently, as well as how many people could potentially transition to a nursing home once this supplemental payment takes effect. AHCA needs to also ensure that providers who agree to provide generator services and bill the supplemental have true dedicated ventilator units with appropriate equipment and staff.

<b>Considerations for supplemental payments as part of prospective payments related to high Medicaid volume and high direct care staffing.</b>	
Supplemental payments related to high Medicaid volume and high direct care staffing were adopted in Section 409.908(2)(b)6., F.S. as detailed in Appendix A. Ten of eleven members support the inclusion of the supplemental payment. One member does not support the supplemental payment for facilities with high Medicaid volume and high direct care staffing.	
Robert P. Asztalos Florida Health Care Association	FHCA fully supports both supplemental payments created by the legislation. Nursing centers with a high Medicaid utilization which consistently staff much higher than the state average should be protected as we move into a new reimbursement system. The direct care supplemental add-on does that and should remain unchanged. FHCA discussed several other additional add-ons and feel there may be a need to address in the future but should only do so if there is additional funding to cover them.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida supports supplemental payments for highly staffed, high Medicaid caseload nursing homes.

Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	As previously discussed, we strongly urge adoption of both of these concepts and support expansion of the supplemental payment to incentivize increasing wages and benefits for direct care and support workers. Such supplemental payments should be designed in a manner where facilities must apply for the supplemental fund, provide evidence that it increased wages, benefits, and/or staffing levels, and include an accountability component that the State can recoup funds that were not spent appropriately. Such a model is used in several states, such as Texas.
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	<i>I do not support this measure.</i>  <i>Theoretically there is already a quality incentive payment for staffing. In general, facilities with a high percentage of Medicaid Patients lose money every day on every Medicaid resident. If there is a need to make adjustments for this, I recommend that it be done on the basis of high percentage of Medicaid residents in combination with high acuity of Medicaid residents. I would recommend employing a case-mix (acuity) adjustment that could be obtained using a modified RUGS IV 48 grouper methodology.</i>
Beverly Williams Richards, Mitchell & Company, PA	I am in support for supplemental payments for high Medicaid/high direct care staffing. I would recommend that PBJ data be used to compute this when available.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Phase-in timeline and transition payments during phase-in</b>	
Section 409.908(2)(b)7., F.S. (Appendix A) outlines the phase-in timeline and reimbursement methodology. Nine of eleven members support the phase-in timeline and transition payments during phase-in in legislation. Two members recommend delaying implementation until 2019.	
Robert P. Asztalos Florida Health Care Association	Because of wide variances in reimbursement for centers moving from the current, cost-based system to a PPS, FHCA supported the five-year transition period that is in the legislation. The three-year period for holding harmless those centers experiencing rate reductions under the new system plus the additional two years of limiting losses is a fair amount of time for providers to make the necessary changes to their



	business model. At this time FHCA does not believe there needs to be any additional changes to the phase-in timeline or transition payments.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida supports the transition period established in the 2017 Appropriations Act, however, as demonstrated by the working group discussions during the three meetings, more time is needed to develop the details of the new PPS plan. Delaying implementation until 2019 would be prudent.</i>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	Current phase in schedule and funding parameters provides for a reasonable transition and should not be changed.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
<i>Mark Reiner, MD Catholic Health Services</i>	<i>I support the proposal in part.  The proposed phase-in timeline and transition payments for the first five years are acceptable. However, in view of the inability of the working group to come to a consensus, I believe it is reasonable to delay implementation for an additional year (2019).</i>
Beverly Williams Richards, Mitchell & Company, PA	I support the proposal of a 3-year phase-in with no more than 5% change each year.
Jennifer Ziolkowski Opis Senior Services Group	I believe the currently proposed transition payment of 3 years of hold harmless and an additional 2 years where losses are capped is more than fair. I believe the legislature listened to the concerns of the providers and carefully crafted a proposal that would allow providers adequate time to adapt.

<b>Frequency of rebasing under prospective payments</b>	
Section 409.908(2)(b)5., F.S. (Appendix A) requires rebasing every fourth year. Additional details may be found in the Recommendations Report in Appendix C. Ten of eleven members support the legislation related to rebasing. One member recommends rebasing more frequently.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the Legislature's language to rebase every three years. This creates a fair system that allows system wide cost changes to be captured.

Erwin P. Bodo LeadingAge Florida	LeadingAge Florida supports a three-year rebasing of prices and related floors.
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>1199SEIU is concerned that, although quality and property costs are rebased annually, non-property costs (including all costs associated with care) are rebased only every three years. Along with the radical flattening of rates to the median, we urge that the Legislature amend the plan to include more frequent rebasing of direct, indirect and operating components.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	No change.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I support rebasing every 4 <sup>th</sup> year.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Exemptions from prospective payments</b>	
Section 409.908(2)(b)8., F.S. (Appendix A) makes Pediatric, Florida Department of Veterans Affairs, and government-owned facilities exempt from reimbursement under the prospective payment system. Ten of eleven members support the exemptions in legislation. One member does not support the exemption of Veterans' or government facilities from the prospective payment system.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the Legislature's exemptions from the PPS which include pediatric and government run facilities. Those facilities should remain reimbursed on a cost basis. FHCA does not believe there is a need for any other groups to be exempt from PPS.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida supports the exemptions for governmental and pediatric nursing homes from the PPS system and continuing setting payment rates using the current payment system.  LeadingAge Florida recommends that the prices and floors for the PPS system be calculated using all Medicaid participating nursing homes

	regardless of whether they will be paid under PPS or the current payment system.
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
<i>Mark Reiner, MD Catholic Health Services</i>	<i>I believe it is appropriate to exclude Pediatric facilities from the PPS system. However I do not support exemption of Veteran's or governmental facilities. I do not believe that the residents of these facilities differ significantly from those of the "average" LTC nursing home. If there is concern that there is variation in complexity, then the appropriate way to address this in a PPS reimbursement system is via a Case Mix methodology.</i>
Beverly Williams Richards, Mitchell & Company, PA	I support the proposed exemptions.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Budget neutrality for property and non-property related cost components</b>	
Section 409.908, F.S. does not consider budget neutrality separately for the property and the non-property components. This methodology was proposed in the Recommendations Report (Appendix D), but will not be included in the prospective payment system because it was not adopted into statute. Ten of eleven members support the legislation. One member recommends determining the budget neutrally separately for the property and non-property components.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the Legislature's methodology. It is important that the state incentivize older nursing homes to renovate or rebuild to keep up with the changing demands of our residents.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida has been and remains an advocate for maintaining separate budget neutrality for the property component and the non-property component. Implementing a PPS system with 100% funding of property would automatically lead to inadequate funding of the operating and care related cost components. That is, 100% funding of</i>

	<p><i>the Fair Rental Value System would divert funding from care related centers, such as direct care staffing. Under the proposed PPS system operating and care related prices are set below median cost levels. This creates extraordinary pressure on nursing home operators to cut back on care and administration in order to maintain financially sound operations. Funding property at 100% just exacerbates this problem.</i></p> <p><i>Should additional funding become available these dollars should be directed to increase the prices paid for care related components and/or to increase funds dedicated to the Quality Incentive.</i></p>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	It is important that property be fully funded to provide for property and technology improvements.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I am in support of fully funding the FRVS portion of the rate initially. Florida Medicaid has not funded the renovation of facilities for the last 30+ years which has resulted in facilities that have not been modernized or updated. This is especially pronounced for high Medicaid buildings and has a direct impact on patient care.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Interim rate changes for both property and non-property related cost components</b>	
There is no proposal currently in place in either the legislation or the Recommendations Report that addresses reimbursement for interim rate changes. Four members have provided recommendations related to interim rate changes.	
<i>Robert P. Asztalos Florida Health Care Association</i>	<i>FHCA supports continuation of the current interim rate criteria with minor changes necessary to make it fit the PPS methodology. Interims should be paid for new mandates or requirements from the state or federal government that have cost increases.</i>

Erwin P. Bodo LeadingAge Florida	<i>LeadingAge Florida recommends that if implementation of federal or state laws, rules, or regulations require nursing homes to increase their operating, care related, or building related expenditures in excess of 1% of the applicable component floor, price, or FRVS rate, the relevant rate component for all nursing homes be supplemented with a commensurate add-on amount and the relevant floors, prices, and FRVS calculations be adjusted to account for the increase.</i>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	<i>1199SEIU supports interim and supplemental payments for one-time costs (such as for hurricane preparation and recovery) and for ongoing mandates, such as insurance mandates and minimum wage increases. As we mentioned already, we also believe that the plan should include an ongoing supplemental payment for staffing and wage/benefit levels which exceed state medians for the industry.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	I support the Agency's proposal.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	<i>In situations beyond the control of the provider, an interim rate provision for both property and non-property costs is recommended. The current reimbursement plan refers to changes in state or federal requirements but it would be recommended that natural disasters be added to the reasons for an interim rate to be granted.</i>
Jennifer Ziolkowski Opis Senior Services Group	

<b>Annual inflation adjustments of non-property related rate components</b>	
The Recommendations Report (Appendix C) proposes inflationary increases yearly for the operating, direct, and indirect care components. A yearly update to the quality incentive model is also recommended. There is consensus among members to calculate inflationary increases as proposed in the Recommendations Report.	
Robert P. Asztalos Florida Health Care Association	FHCA supports an annual inflation increase between rebase years.
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida recommends that the existing inflation adjustment methodology, revised to account for the reallocation of various cost

	centers to the operating, indirect care and direct care cost components, be used to adjust component prices and floors.
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	I support annual inflation adjustment during non-rebasing years.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I support annual inflation adjustments of non-property related rate components using the same methodology/indices as the current cost-based system.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Payment for generator upgrades per the Emergency Rule</b>	
There is no proposal currently in place in either the legislation or the Recommendations Report that addresses reimbursement for payment for generator upgrades. Four members have provided recommendations related to Medicaid funding for generators.	
<i>Robert P. Asztalos Florida Health Care Association</i>	<i>FHCA believes that the emergency generator rule will cause significant financial hardship on providers and that the state should work on providing reimbursement for these costs through a separate supplemental payment similar to the fire sprinkler methodology from the past.</i>
Erwin P. Bodo LeadingAge Florida	
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	

Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	<i>I support the Agency reimbursement for generator rule compliance.</i>
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	<i>Notwithstanding the unclear status of Governor Scott's emergency rule, I believe that the Legislature should move forward in mandating all facilities have adequate emergency power – albeit in a more realistic timeline. But there should also be a process to reimburse facilities for the added expense of upgrading their back-up generators. Adding one more “unfunded” mandate to an already ever-growing list places an undue burden on facilities, especially as whatever reimbursement schema that is in place does not (and most likely will not) cover the costs of treating Medicaid residents.</i>
Beverly Williams Richards, Mitchell & Company, PA	<i>I would propose that all costs of complying with the Governor's Emergency rule be paid as an add-on to the current PPS rate. Since these will be capitalized costs, it could be paid over 3-4 years (or until rebasing) using a methodology similar to the reimbursement for the Medicaid portion of sprinkler systems that were required for all facilities in 2010.</i>
Jennifer Ziolkowski Opis Senior Services Group	

<b>FRVS payment parameter values – minimum/ maximum square footage per bed</b>	
The FRVS payment parameter values are outlined in Section 409.908(2)(b)1.g., F.S. as detailed in Appendix A including the minimum square footage value of 350 per bed and the maximum square footage of 500 per bed. Eight of eleven members support the FRVS parameters in legislation. Two members recommend modification of the minimum square footage per bed parameter. One member recommends modifications to the minimum square footage and other components of the FRVS.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the FRVS parameters as included in the legislatures PPS proposal. FHCA believes that paying a minimum square footage per bed at 350 square feet incentivizes smaller buildings to upgrade patient room size and provides adequate funding where they have to rebuild at current patient centered care room sizes.
Erwin P. Bodo LeadingAge Florida	<i>LeadingAge Florida opposes retaining the 350-500 square feet per bed range for the calculation of the FRVS rates, and recommends reverting to the Navigant proposed 100-500 square foot limits.</i>  <i>Of the 643 facilities in the Navigant study, 321 have fewer than 350 square feet per bed. The minimum number of square feet per bed is 34 and the maximum is 1,310.</i>

	<i>Using the Navigant proposed limits of 100-500 square feet, annual FRVS payments are reduced by \$21.2 million. These funds could then be used to increase direct and indirect care related payments.</i>
Martin Casper Self Employed Nursing Home Consultant	
<i>Dale Ewart 1199SEIU, United Healthcare Workers East</i>	<i>Facilities should not receive payment for a minimum of 350 square feet/resident unless this reflects their actual condition. If facilities are to receive the higher reimbursement, then upgrades to the higher square footage should be required by a date certain.</i>
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	I support the current legislation.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
<i>Mark Reiner, MD Catholic Health Services</i>	<i>I have concerns related to the FRVS calculations that pertain to the calculation of Land Value and Equipment Value. The land value calculation fails to consider variances in land values in different parts of our state. Construction costs, which are fairly standard across the entire state, are driving the land value – this fails to recognize the cost of land in more expensive areas. Therefore, facilities located in areas where land costs are higher are not receiving proportionate increases in reimbursement. In regards to the \$8,000/bed equipment allowance, facilities that choose to invest in patient care software and other technology and equipment that advances quality of care, creates efficiencies, etc. are not compensated for additional investment.</i>  <i>I am also concerned about the setting of a minimum square footage per resident. It was stated during the discussions during the third meeting of the working group on November 13 that any facility that fell below this minimum would be getting excess compensation – and it was strongly implied that they would use these monies to do renovations. However there is nothing in this proposal that requires them to do extensive remodeling and there is no phase out of the reimbursement if they fail to do so.</i>
Beverly Williams Richards, Mitchell & Company, PA	Although it may seem that having a minimum square footage of 350 square feet per Statute is over-reimbursing facilities, I think that the facilities that are less than 350 square feet per bed are typically older and will need more renovations. Perhaps keeping this minimum higher initially will help these facilities make needed renovations and modernizations within the next couple of years. After that, this could be re-evaluated to possibly decrease the minimum to 100 square feet which was recommended by the Navigant study.
Jennifer Ziolkowski	



Opis Senior Services Group	
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<b>Rate setting for newly constructed providers without cost history</b>	
Rate setting for newly constructed facilities is detailed in the Recommendations Report (Appendix E). Ten of eleven members support the rate setting as outlined in the Recommendations Report. One members recommends a change to the rate setting methodology for new facilities.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the criteria proposed by Navigant and AHCA.
<i>Erwin P. Bodo LeadingAge Florida</i>	<i>LeadingAge Florida recommends that newly constructed facilities and existing facilities entering the Medicaid program for the first time be paid the geographic class average operating, direct care, and indirect care rates. For these facilities, the FRVS rate should be based on documented property related costs.</i>
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	I support the Agency/Navigant recommendations.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I support the Navigant plan of paying the median until an initial cost report is filed and assuming a 50% quality score. In addition, budgeted FRVS and pass-throughs will be paid until an initial cost report is filed.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Timeliness of audits and desk reviews</b>
Section 409.908(2)(b)7., F.S. (Appendix A) requires audited cost reports to be used for the rebasing rate semesters. The Recommendations Report (Appendix F) provides additional details. There is consensus related to the time frame associated with auditing cost reports. Three members have suggestions related to the process.

Robert P. Asztalos Florida Health Care Association	<i>FHCA would like to see the same cost report year audit for each provider with a third of the audits in each year. That would ensure that costs are comparable amongst all providers. FHCA also would like AHCA to increase use of desk reviews and scale back the audit process to fit into the new PPS rebasing timelines.</i>
Erwin P. Bodo LeadingAge Florida	LeadingAge Florida does not have any recommendations for this topic.
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	<i>I support the Agency's proposal, but recommend scaling back the audit process and included categories for the purpose of meeting PPS timelines.</i>
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	<i>Since the current Medicaid audit assignments are every 5 years, this should change to every 3 years (or as frequently as rebasing). In addition, the scope of the audits will need to change to address items with more of a direct impact on the rates (capital renovations, pass-throughs for taxes/insurance) and to make sure that expenses are properly stated. If facilities are required to have an external financial audit, this could possibly be utilized to make sure expenses are correct, in total, to steam-line the Medicaid audit process.</i>
Jennifer Ziolkowski Opis Senior Services Group	

<b>Rate calculations for facilities that remain under cost-based reimbursement</b>	
The rate calculation methodology for providers who are exempt from the prospective payment system are included in the Recommendations Report (Appendix G). There is consensus among members to use the rate calculation methodology outlined in the Recommendations Report for facilities exempt from the prospective payment system.	
Robert P. Asztalos Florida Health Care Association	FHCA supports the criteria proposed by AHCA.

Erwin P. Bodo LeadingAge Florida	LeadingAge Florida recommends that rate calculations for facilities that remain under cost-based reimbursement remain identical to the current rate setting process using cost data for all Medicaid participating nursing homes in the cost component ceiling calculations.
Martin Casper Self Employed Nursing Home Consultant	
Dale Ewart 1199SEIU, United Healthcare Workers East	All facilities costs, including those remaining under cost-based reimbursement, should be used to determine medians for PPS reimbursement. Likewise, all facilities costs, including those under PPS, should be used to set ceilings and limits for those facilities remaining under the current reimbursement system.
Robert Goldstein Menorah Manor	
Scott L. Hopes CliniLinc, Inc	I support the agency proposal.
Jennifer Langer Jacobs Sunshine Health	
Keith A. Myers MorseLife Health System	
Mark Reiner, MD Catholic Health Services	
Beverly Williams Richards, Mitchell & Company, PA	I support AHCA's plan to use the current Medicaid reimbursement methodology utilizing all facilities to compute ceilings for the exempted facilities.
Jennifer Ziolkowski Opis Senior Services Group	

<b>Closing Comments</b>	
Robert P. Asztalos Florida Health Care Association	FHCA and our more than 550 skilled nursing facility members statewide appreciate the work put in by the working group in regards to implementation of the Medicaid Prospective Payment System (PPS) and the opportunity to submit the following comments regarding the changes discussed to this point. FHCA worked collaboratively with our members and the legislature to take the Navigant proposal and turn it into a system that has broad based consensus and almost everyone feels is the right way to accomplish the goal of moving nursing home rates away from cost-based reimbursement. We feel that the legislature acted prudently and smartly in passing a system which rewards centers that achieve quality goals aimed to improve staffing and other measures focused on better health outcomes for seniors. It also offers incentives to centers for making renovations and improvements that enhance resident quality of life. The current cost-based system is obsolete and does not work in a managed care

	<p>environment; it lacks budget predictability for providers as well as the state. It fails to measure and reward centers' quality advancements in any meaningful way and provides no incentive for efficient use of taxpayer dollars. Its lengthy audit and appeal timelines is administratively unwieldy. It also lacks any financial incentive or reimbursement for providers to make renovations on buildings that are, on average, 36 years old.</p> <p>Any changes proposed by this group should be made prospectively and not retroactively. It is not fair to change the rules of the game after it has been played. FHCA strongly supported the creation of a technical advisory working group to review and make recommended changes to PPS but felt at the time and still do that this group should meet as we are coming out of the transition period and have data that reflects changes in behavior from shifting away from a cost based system.</p>
<p>Erwin P. Bodo LeadingAge Florida</p>	<p>LeadingAge Florida has been and continues to remain supportive of a fair and equitable nursing home prospective payment system (PPS). The proposed PPS is a good start and could be transformed into a fair and equitable system with just a few minor changes. Without these changes, the new payment system will create extreme hardship on some of the state's best nursing homes and bestow windfall profits on a number of habitually underperforming facilities.</p> <p>During the November meeting of the PPS working group a public comment suggested that the Virginia PPS is very similar to the one proposed for Florida and it works well. LeadingAge Florida reviewed the salient factors of the Virginia PPS and finds that it is in no way comparable to that proposed in Florida. Virginia uses resource utilization grouping based adjustments for individual nursing home residents and has both geographic and size based payment classes. Further, Virginia PPS prices are set at 105% of the class median for direct care and 100.7% for indirect care. This is a stark contrast to the Florida proposal that ignores case-mix adjustments, ignores facility size differences, and sets direct care prices at 100% of the class median and indirect care prices at 92% of the class median.</p> <p>LeadingAge Florida recommends the following changes to the proposed PPS system to ensure that it is fair and equitable and provides adequate resources for continued high quality of care:</p> <ul style="list-style-type: none"> <li>• Revise the geographic regions to include AHCA Districts 8 – 11 in the South Region and the other districts in the North Region;</li> <li>• Incorporate payment classes for facility size;</li> <li>• Maintain separate budget neutrality for property and non-property components;</li> <li>• Base FRVS calculations on 100-500 sq. ft. limits;</li> <li>• Exempt quality points earned due to year-to-year improvement from the point threshold;</li> <li>• Increase direct care and indirect care prices and floors to more reasonable levels; and</li> <li>• Set initial rates based on the September 1, 2017 rates.</li> </ul>

	<p>LeadingAge Florida notes that additional funding for an orderly transition to PPS must be made available. Without additional dollars, the transition will be financially painful for some of the highest quality nursing homes and will likely lead to reductions in staffing and a potential decline in quality of care.</p> <p>LeadingAge Florida appreciates the opportunity to serve on the PPS working group and sincerely thanks all AHCA staff that were part of the process for the transparent process and for conducting the meetings in a fair and professional manner.</p>
<p>Martin Casper Self Employed Nursing Home Consultant</p>	
<p>Dale Ewart 1199SEIU, United Healthcare Workers East</p>	<p>During the Prospective Payment System review process, beginning with the Navigant study and report, 1199SEIU expressed significant concerns about the reimbursement structure proposed by Navigant. Those comments (September 20, 2016, September 22, 2016 and November 17, 2017) were shared with the Agency and Navigant. Other stakeholders expressed similar concerns.</p> <p>Unfortunately, our concerns with the PPS reimbursement structure have not been sufficiently addressed by the Legislature. The proposals presented to the working group in some cases improve on the Navigant proposal, but overall we continue to believe the Navigant model, as enacted by the Legislature, is significantly flawed and needs more than minor adjustments.</p> <p>While we have a number of specific issues with the Navigant model, we have two major interrelated concerns:</p> <p>The dramatic leveling-out of direct care reimbursements (between 95 and 100% of median costs) will be disruptive to the industry. It will punish high-quality, high-cost providers, making it difficult for them to sustain the levels of quality care they have achieved, and will reward low-cost providers by transferring resources to them without any mandate that the additional reimbursements be spent on quality care.</p> <p>The Navigant PPS model treats staffing as another “commodity” which should be reimbursed on a “price”, rather than “cost” basis. The quantity, quality and correct deployment of staff play a larger role in care outcomes than any other factor. Nursing home workers are underpaid, underinsured, and lack adequate retirement benefits A price based methodology encourages providers to hold down staffing costs rather than invest in the right number of quality staff, inappropriately prioritizing cost concerns over quality care, This incentive runs counter to the public policy goal of the highest possible quality care for Florida’s nursing home residents.</p> <p>Reimbursement accountability should continue to be a priority for the State. As Florida undergoes dramatic changes to simplify its reimbursement system, the Agency should set a statewide standard for</p>

	fiscal year filings with uniform start and end dates. Nursing homes are largely funded by public dollars, and transparency in financial reporting is essential to public accountability.
Robert Goldstein Menorah Manor	I believe that the proposed PPS plan, scheduled for implementation October 1, 2018 still has significant flaws. The majority of high quality, high cost Homes stand to have their rates significantly reduced while poor quality, low cost Homes stand to gain a windfall of dollars. In addition, Homes that gain a windfall of dollars have no obligation to put that money back into care and services or quality. This does not make sense and threatens to undermine the best Nursing Homes in the State. High quality Homes that already are losing money on Medicaid, and are slated to lose additional Medicaid reimbursement, will have no choice other than to reduce their Medicaid census. This PPS plan is not good public policy. I urge AHCA and the Legislature to examine the fundamental flaws in this model which undermine the achievements and progress our high quality nursing homes have made to date.
Scott L. Hopes CliniLinc, Inc	<p>I am in full support of the Prospective Payment System (PPS) model as passed by the Florida Legislature during the 2017 session. I believe that it is a plan that has broad industry sector support and buy-in. We do not have new or additional data now that is different than we had during the Navigant Consulting process or the legislative session and negotiations which would justify a change prior to implementation.</p> <p>The Agency for Health Care Administration (AHCA), the University of South Florida, Muma College of Business, Navigant, industry stakeholders, Florida Health Care Association, Leading Age, and numerous individual experts, participated in a process which spanned more than two years. Under the leadership of AHCA and through the legislative process, we arrived at a solution and transition to implement a PPS reimbursement system which has the broadest support I believe possible. I believe the methodology adopted by the legislature this year, provides the best value and quality incentives to foster continuous quality improvement for our frail, elderly, and aging residents. While this is a transformational beginning, I do believe, as we experience the change and collect data post implementation, we will all benefit from a re-gathering of this or a similar panel, to evaluate and recommend improvements grounded in the first two years of experience under PPS.</p>
Jennifer Langer Jacobs Sunshine Health	Sunshine Health applauds the State of Florida for assembling this group to work on improvements to the state's nursing home systems by aligning reimbursements with meaningful quality and outcome measures. We appreciate AHCA for facilitating the respectful and valuable conversations during each meeting. We appreciate this opportunity to be included and are excited for the stronger relationships it allowed us to forge with our partners in the provider community. As this system is implemented we look forward to the benefits these efforts will yield, including increased availability of ventilator beds and other measures that will increase access to quality care for our state's most vulnerable population.
Keith A. Myers	

MorseLife Health System	
Mark Reiner, MD Catholic Health Services	<p>I believe that transition to a PPS methodology for reimbursement is reasonable. My primary objection is that I do not believe the current proposal is a true PPS system. A valid PPS proposal would evaluate the clinical complexities of the nursing home resident and reimburse costs (especially Direct and Indirect) based on these factors – in other words using a validated Case Mix methodology. There need to be adjustments based on location (accounting for cost of living/wage index differences) as well as mandatory (both Federal and State) requirements that are not attributable to the established cost centers.</p> <p>I do not feel the current proposal adequately addresses these concerns and believe it in the interest of achieving fair and just reimbursement system, the Legislature should reexamine the current law and delay implementation until an equitable system can be designed.</p>
Beverly Williams Richards, Mitchell & Company, PA	<p>The basic Navigant plan, as modified and adopted by the legislature, achieves the goals of promoting quality care while being (relatively) simplistic and predictable. As discussed in the 3 meetings of this working group, there is much disagreement regarding the quality measures which are not addressed in Statute. Instead of changing any of the measures included in the Navigant study, I think that the current indicators/measures should be re-evaluated in the future and possibly be replaced at the same time as rebasing to address any concerns.</p>
Jennifer Ziolkowski Opis Senior Services Group	<p>As a general principle I think any changes made should be made prospectively and after providers have been made aware of the changes with plenty of opportunity to adapt to the changes before they begin to impact their reimbursement system. I also feel that the PPS that passed the legislature last session is a model that has broad industry consensus and has significant protections built in to allow nursing homes a very generous five years to adapt to any changes. This system should be allowed to be fully implemented before we start making changes and I would be in support of leaving it as is for the time being.</p>

## APPENDIX A

The 2017 Florida Statutes Section 409.908

### **409.908 Reimbursement of Medicaid Providers**

*Section 8, ch. 2017-129*, amended subsection (2), effective October 1, 2018, to read:

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under part VIII of chapter 400 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement shall be determined by averaging the nursing home payments in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions in the General Appropriations Act, the agency shall establish and implement a state Title XIX Long-Term Care Reimbursement Plan for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:



- a. Peer Groups, including:
  - (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee Counties; and
  - (II) South-SMMC Regions 10-11, plus Palm Beach and Okeechobee Counties.
  
- b. Percentage of Median Costs based on the cost reports used for September 2016 rate setting:
  - (I) Direct Care Costs.....100 percent.
  - (II) Indirect Care Costs.....92 percent.
  - (III) Operating Costs.....86 percent.
  
- c. Floors:
  - (I) Direct Care Component.....95 percent.
  - (II) Indirect Care Component.....92.5 percent.
  - (III) Operating Component.....None.
  
- d. Pass-through Payments.....Real Estate and Personal Property Taxes and Property Insurance.
  
- e. Quality Incentive Program Payment Pool.....6 percent of September 2016 non-property related payments of included facilities.
  
- f. Quality Score Threshold to Quality for Quality Incentive Payment.....20th percentile of included facilities.
  
- g. Fair Rental Value System Payment Parameters:
  - (I) Building Value per Square Foot based on 2018 RS Means.
  - (II) Land Valuation.....10 percent of Gross Building value.
  - (III) Facility Square Footage.....Actual Square Footage.
  - (IV) Moveable Equipment Allowance.....\$8,000 per bed.
  - (V) Obsolescence Factor.....1.5 percent.
  - (VI) Fair Rental Rate of Return.....8 percent.
  - (VII) Minimum Occupancy.....90 percent.

- (VIII) Maximum Facility Age.....40 years.
- (IX) Minimum Square Footage per Bed.....350.
- (X) Maximum Square Footage for Bed.....500.
- (XI) Minimum Cost of a renovation/replacements.....\$500 per bed.

h. Ventilator Supplemental payment of \$200 per Medicaid day of 40,000 ventilator Medicaid days per fiscal year.

2. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility, allowable therapy costs, and dietary costs. This excludes nursing administration, staff development, the staffing coordinator, and the administrative portion of the minimum data set and care plan coordinators. The direct care subcomponent also includes medically necessary dental care, vision care, hearing care, and podiatric care.

3. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate, including complex medical equipment, medical supplies, and other allowable ancillary costs. Costs may not be allocated directly or indirectly to the direct care subcomponent from a home office or management company.

4. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5. Every fourth year, the agency shall rebase nursing home prospective payment rates to reflect changes in cost based on the most recently audited cost report for each participating provider.

6. A direct care supplemental payment may be made to providers whose direct care hours per patient day are above the 80th percentile and who provide Medicaid services to a larger percentage of Medicaid patients than the state average.

7. For the period beginning on October 1, 2018, and ending on September 30, 2021, the agency shall reimburse providers the greater of their September 2016 cost-based rate or their prospective payment rate. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective payment rate, using the most recently audited cost report for each facility. This subparagraph shall expire September 30, 2023.

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

## **APPENDIX B**

2016 Nursing Facility Payment Recommendations Report, Quality Incentive Program Excerpt

### **8 Quality Incentive Program**

#### **8.1 Introduction**

One significant opportunity while designing a new payment system for statewide nursing facility reimbursement is the ability to introduce a quality incentive program as an element of the overall reimbursement model. The current cost-based system does not account for delivery of high quality services, which is a missed opportunity for the Agency as a significant payer of long-term nursing facility care. While the current system pays for costs, it does not significantly define expectations around quality of services rendered, and expectations for how that quality translates into resident experience and health outcomes. In short, the agency is challenged to identify a return on investment for nursing home services paid for using Medicaid funds. The Agency expressed its intent to incorporate a quality incentive program to stakeholders early in the design process, and received wide support for a strong quality incentive within the prospective payment system, so long as the incentive was constructed in a manner that:

1. Included evidence-based quality indicators that demonstrably impact care outcomes and quality of life for nursing home residents,
2. Did not significantly drive administrative burden for nursing facilities by adding new measures that would require additional tracking and reporting above and beyond current reporting required by the Centers for Medicare and Medicaid Services (CMS),
3. Rewarded top-performing providers, while allowing some opportunity for providers with significant improvement to benefit from a quality incentive payment as well.

When considering what measures to include in a quality incentive program, Navigant deliberately chose quality standards that we believe drive quality of care and quality of life for residents. Our model incorporates measures that “hinge” the quality standards expected of nursing homes to quality measures for the statewide managed long-term care programs. We believe coordinating quality standards across the long-term care continuum will drive increased coordination and continuity of care as long-term care consumers transition across the continuum of care. Our recommended quality measures drew from pre-existing measures that nursing facilities are already tracking and reporting on in some form or fashion to CMS, thereby reducing any additional administrative burden.

#### **8.2 Discussion**

The quality incentive payment represents a dramatic change in the way in which AHCA has funded long term care. Historically, payments were made using facility-specific rates based upon cost, and generally relied on this approach to lead to the provision of appropriate quality of care. Our recommended quality incentive program within the NPPS is intended to maximize the value of public expenditures by explicitly measuring and rewarding better nursing home performance.

##### **8.2.1 Size of the Quality Incentive Program**

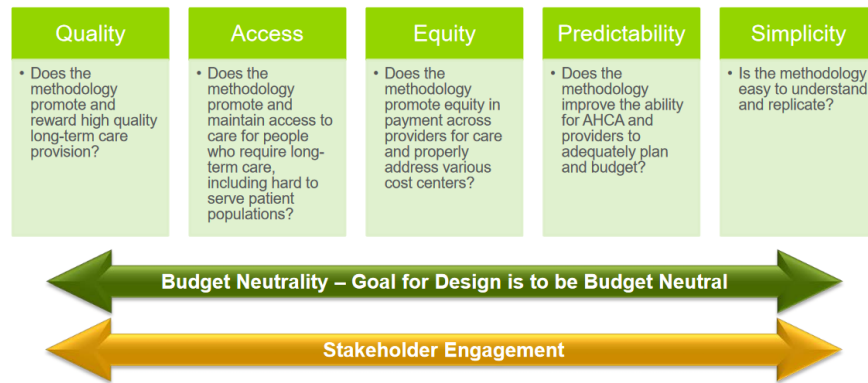
Throughout the NPPS design process, we received feedback from various stakeholder groups, and virtually all supported the implementation of a quality incentive payment component, however, feedback regarding the size of the program varied. Some stakeholders recommended that the quality incentive component be no more than two percent of total payments under the new system, while others argued for a minimum of ten percent, with that amount increasing over

time. Others suggested phasing in the quality component over time, beginning at two percent in the first year and increasing it in future years to a maximum of five percent.

### 8.2.2 Process Followed to Develop the Quality Model

Developing a quality incentive program requires balancing a number of trade-offs and competing priorities. The quality incentive payment has the potential to significantly impact the quality of care and life of residents, as well as the quality of nursing facility staff and program administrators.

**Figure 14. Application of guiding principles to establish quality incentive payments.**



The Agency conducted an inclusive process, soliciting input from a wide array of stakeholders to help determine the quality incentive measures. Potential measures were presented to stakeholders and their comments were solicited during and after several public hearings, and during other meetings with individual stakeholder organizations. Some stakeholder feedback became the impetus for changes to the model while other suggestions were considered less consistent with the guiding principles set forth for this project, and were not included in the model.

### 8.2.3 Framework

There are several quality initiatives underway in Florida, and nationally, that are specifically designed to improve the quality of care in nursing homes. These include: the federal CMS Five Star rating system, the National Partnership to Improve Dementia Care in Nursing Homes and the Advancing Excellence in America’s Nursing Homes Campaign, all targeting specific domains of care within long-term care. Within Florida, the Nursing Home Gold Seal Award and the Florida Nursing Home Guide, as well as the state survey, all serve as additional layers of quality monitoring and reporting. Several of these are discussed in more detail later in the report.

When structuring the Florida NPPS quality incentive program, the Donabedian Model (DM) for evaluating quality health care was used as the conceptual framework. While there are several other quality of care frameworks in use, the DM remains one of the most heavily used and well researched models for measuring quality of care in a variety of healthcare settings. In the DM model, there are three primary areas in which information on quality of care can be collected.

These areas have been translated to represent measures for the purpose of building the Florida NPPS quality incentive program: Structural Measures, Process Measures and Outcome Measures.

The **Structural** measures are organizational characteristics associated with the provision of care. These include measures related to facility size, age, staffing, sources of payment, occupancy, etc. **Process** measures represent all actions that directly impact the resident. These measures may include timeliness and accuracy of diagnosis, treatment, and preventive care as well as referrals to other healthcare services (i.e. therapy, acute care, etc.) or care delivery. The **Outcome** measures represent the effects of care to patients including changes in health status, functional ability, and preventable illness and other healthcare conditions.

#### **8.2.4 Data Sources**

Based upon the guiding principles and the need for budget neutrality, as well as a desire for a quality model to be easily understood, it was decided that measures should be publicly accessible and should come from sources which already exist, to the extent possible. There was consensus among all stakeholders that enough information is already collected, and to add more measures or reporting would represent an administrative burden requiring further time and resources. To that end, nearly all of the data utilized in the development of the quality incentive model is based on information currently reported by nursing facilities. In addition, most of the information is currently publicly accessible through the web from either the CMS, Joint Commission, Association for Health Care Administration or the Florida Agency for Health Care Administration. Only the staffing data retrieved from the Nursing Home Cost Reports and the CMS 671 Reports are not currently posted to the web, but are available by request to the Agency.

### **8.3 Recommendation**

#### **8.3.1 Size of the Quality Incentive Payment Program**

After significant discussion with the Agency and consideration of stakeholder input, we recommend setting aside for the quality incentive component a smaller amount in the first year of implementation and gradually increasing the size of the program in subsequent years. We are suggesting the first year of the Quality Incentive Program be funded with an amount totaling seven percent (7%) of current non-property related payments. This total using SFY 2016/17 rates is \$216,884,906. In addition, we recommend gradually increasing this percentage by setting it to eight percent (8%) in year two of the NPPS, nine percent (9%) in year three, and settling at ten percent (10%) in year four and beyond. It is important that the quality incentive component be established in a way that creates sufficient incentive for providers to change how they provide care. Making the incentive too small would provide little such incentive. At the same time, too large of an incentive payment would overly reward quality of care, and could jeopardize those facilities who are poorer performing by creating such a low per diem rate that it would be difficult to make the changes necessary to improve quality of care. We believe seven percent is significant enough to drive commitment to quality, by providing substantive payment increase to those facilities that demonstrate high quality, while also recognizing those facilities who demonstrate significant improvement and movement toward high performance. As the largest payer for statewide long-term care, we believe the criteria established represents a strong composite of how we measure value in the delivery of the nursing home care and services that Medicaid funds.

#### **8.3.2 NPPS Quality Incentive Model**

Measurement of quality in a nursing facility setting is not a perfect science and will continue to evolve. Our NPPS quality incentive model utilizes a combination of measures in order to most

accurately identify and reward nursing facilities providing the highest levels of care. The methodology provided promotes quality and aligns with federal quality measures, while considering state-specific measures that incentivize clinical performance and recognize commitment to quality. All of the clinical measures indicated are evidence based and have been found to indicate high quality of care or high quality of life for people residing in nursing homes. The quality measures included in our model represent a clear summary of what the State expects from Medicaid-funded nursing home care, and provides a framework that the nursing home industry can use as a focal point when identifying areas of opportunity for improvement or sustaining high performance. The quality measures selected for inclusion in the proposed quality incentive include:

- *Process Measures* – Flu Vaccine, Antipsychotic, Restraint
- *Outcome Measures* – UTI's, Pressure Ulcers, Falls, Incontinence, Decline in ADLs
- *Structural Measures* – Staffing, CMS 5 Star, Florida Gold Seal, Joint Commission Accreditation, AHCA National Quality Award

Scoring for each of these measures is provided in Figure 15 below.

Throughout the NPPS design process, it was recognized that several new quality measures will be available online at a later date, through Nursing Home Compare. A number of these future measures are expected to be strongly correlated with high quality of care and would thus make appropriate replacement measures or additions to those used in the current model. Future measures to consider include: staff turnover and retention, types of staffing (activity staff, social work, nursing, dietary, administration, etc.), ability to ambulate independently and use of anti-anxiety or hypnotic medications. Our proposed model is designed to accommodate more appropriate measures as they become available, either as new measures, or as replacement for existing measures. Indications are that CMS recognizes the value of resident and family satisfaction surveys as reliable indicators of quality of care. Additionally, available research on quality of life and quality of care for residents in long term care facilities suggests that resident or family satisfaction surveys, if conducted appropriately, should provide useful insight into the quality of life for residents. As such, Navigant recommends that that Florida consider developing a resident or family satisfaction survey for consideration as a future measure of quality included the quality incentive model.

**Figure 15. NPPS quality incentive model.**

Process Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points Per Facility
<b>Flu Vaccine</b>	20% year-over-year improvement. In first year, improvement is calculated as the change from the year preceding the base year to the base year measurement.	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
<b>Antipsychotic</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Restrained</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
Outcome Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points Per Facility
<b>Urinary Tract Infections</b>	20% year-over-year improvement. In first year, improvement is calculated as the change from the year preceding the base year to the base year measurement.	Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Pressure Ulcers</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Falls</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Incontinence</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Activities of Daily Living</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
Structure Measures	No Points Awarded To Those Under Median	1 Points	2 Points	3 Points	Max Points Per Facility
<b>Combined Direct Care Staffing (RN, LPN, CNA)</b>	N/A	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
<b>Social Work and Activity Staff</b>	N/A	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
Credentials <sup>2</sup>		1 Point	3 Points	5 Points	Max Points Per Facility
<b>CMS 5 Star Rating</b>	N/A	3 Stars	4 Stars	5 Stars	5
<b>Florida Gold Seal</b>	Must Have at least 1 of these 3 Certifications/Accreditations (maximum of 5 points)	N/A	N/A	Awarded	5
<b>Joint Commission Accreditation</b>		N/A	N/A	Awarded	
<b>AHCA National Quality Award</b>		N/A	N/A	Silver or Gold Award	
<b>Total Quality Points Possible</b>					<b>40</b>

<sup>2</sup> Under the Donabedian Model, credentials would traditionally be classified as a structural measure



### 8.3.3 Calculation of Quality Scores

In our recommended model, each facility is able to receive a maximum of 40 points. Points are calculated for each of the domains separately (Process, Outcomes and Structure) on an annual basis and then added together to receive an overall score.

For each individual Process and Outcomes measure, each provider will be ranked based on the percentage of residents who have (or do not have) a particular condition. Providers who are in the top 90th percent of high performers for a particular measure will be awarded 3 points, those scoring between the 75th and the 89th percentiles will be awarded 2 points and those scoring between the 50th and 74th percentiles will receive 1 point. A maximum of 9 points can be achieved for the Process measures and 15 points for the Outcome measures. Providers who score below the 50th percentile still have an opportunity to receive 0.5 points by achieving a 20 percent improvement year over year. For years 2 and 3, the year 1 percentile values will continue to be used, however, individual provider percent improvements will still be measured year over year. (Please see section 9.2.2.4 for further discussion of timing of updates to quality scores.)

The percentile values included in our model for Process and Outcomes measures are shown in Figure 16.

**Figure 16. Process and Outcomes measures percentiles.**

Type	Measure	50th Percentile	25th/75th Percentile	90th/10th Percentile
Process	Flu Vaccine	95.98%	98.95%	100.00%
Process	Antipsychotic	15.52%	10.88%	6.86%
Process	Restrained	0.00%	0.00%	0.00%
Outcomes	UTI	3.47%	1.32%	0.00%
Outcomes	Pressure Ulcers	5.44%	3.29%	1.52%
Outcomes	Falls	2.47%	1.23%	0.00%
Outcomes	Incontinence	51.85%	41.18%	31.82%
Outcomes	ADL	13.00%	8.44%	5.56%
<b>Note(s):</b>				
<ul style="list-style-type: none"> <li>Several measures identified early as potential indicators of quality were excluded due to the lack of variability in scores. Even though the restraint measure fits this criteria, it was kept in the model as both Navigant and the Governance committee felt it was such an important factor for quality of life for residents.</li> <li>The number of restraints reported was so few that the 50<sup>th</sup>, 25<sup>th</sup>, and 10<sup>th</sup> percentiles all came out to 0%. Even so, we chose to keep this measurement in the model because we believe it is important to incent extremely limited use of restraints.</li> </ul>				

For Structural measures, each provider will be ranked annually based upon how they performed in each of the staffing related measures. Providers who are in the top 90<sup>th</sup> percentile for each of the staffing measures will be awarded 3 points, those scoring between the 75<sup>th</sup> and the 89<sup>th</sup> percentiles will be awarded 2 points and those scoring between the 50<sup>th</sup> and 74<sup>th</sup> percentiles will receive 1 point. A maximum of 6 points can be achieved for the Combined Direct Care Staffing and Social Work/Activity Staff measures.<sup>3</sup> Also, Navigant recommends that the Structural measures be updated and re-benchmarked annually as staffing levels can be more quickly adjusted than some of the other quality measures in our model.

<sup>3</sup> It is our understanding that CMS will be reporting new Staffing and Retention measures in the near future. Navigant strongly recommends consideration of these new Staffing and Retention measures once they become available for addition to or replacement of measures within the Structural domain.

The percentile values included in our model for Structural measures are shown in Figure 17.

**Figure 17. Structural measures percentiles.**

Type	Measure	50th Percentile	25th/75th Percentile	90th/10th Percentile
Structure	Combined Direct Care Staffing (RN, LPN, CNA)	3.949	4.240	4.575
Structure	Social worker and Activity Staffing	2.00	2.2125	3.00

The last category, Credentials, allows for a maximum of 10 points. The first Credentialing measure is the CMS 5-Star program. Facilities assigned a rating 3, 4 or 5 stars in this program will receive 1, 3 or 5 points, respectively. The second Credentialing measure enables facilities to gain an additional 5 points by obtaining either a Florida Gold Seal, Joint Commission Accreditation or the American Health Care Association National Quality Award Silver or Gold level.

Using these criteria, quality scores for each individual facility are provided in Appendix F – Quality Scores by Facility.

### 8.3.4 Calculation of Quality Incentive Program Payments

As mentioned in section 8.3.1, we recommend setting aside an amount totaling seven percent (7%) of current non-property related payments for the quality incentive component. Given SFY 2016 rates, this came out to a total of \$216,884,906 available for the quality incentive program. Also in our recommended model, only facilities scoring above the 30th percentile in total quality points are eligible for the quality incentive payments. Once the 70 percent of the facilities that will receive quality incentive payments is identified, a calculation is made to determine the per diem amount per quality point. The first step in this process involves calculating a total day-weighted score using the following formulas:

$$\begin{aligned} \text{Facility Weighted Score} &= (\text{Facility Quality Score}) \\ &\quad * (\text{Facility Annualized Medicaid Days}) \\ \text{Total Weighted Score} &= \text{Sum of Facility Weighted Scores} \end{aligned}$$

The quality incentive payment per point is then calculated as:

$$\text{Quality Payment Per Point} = \frac{(\text{Total Quality Incentive Program Funds})}{(\text{Total Weighted Score})}$$

In our modelling, the Quality Payment Per Point came out to \$1.31917. Finally the quality incentive per diem add-on amount for each facility is calculated as:

$$\text{Quality Per Diem Add-On} = (\text{Quality Payment Per Point}) * (\text{Facility Quality Score})$$

Using these calculations, the quality incentive program per diem add-on amounts for each individual facility are provided in Appendix G – Quality Per Diem Add-On Calculation.

### 8.3.5 Data Sources

The data for the calculations for each of the 12 measures can be retrieved from the sources listed in Figure 18:

**Figure 18. Quality metric data sources.**

Measure	Data Source
Flu Vaccine, Antipsychotic, Restrained, UTI, Pressure, Ulcers, Falls, Incontinence, ADL	<a href="https://data.medicare.gov/data/nursing-home-compare">https://data.medicare.gov/data/nursing-home-compare</a>
Direct Care Staff	Florida 2016 Staffing Data found in Medicaid cost reports
Activity and Social Worker Staffing	Florida CMS 671 Reports
CMS 5 Star	<a href="https://data.medicare.gov/Nursing-Home-Compare/Star-Ratings/ax9d-vq6k">https://data.medicare.gov/Nursing-Home-Compare/Star-Ratings/ax9d-vq6k</a>
Florida Gold Seal	<a href="http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx">http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx</a>
Joint Commission	<a href="https://www.jointcommission.org/accreditation/nursing_care_centers.aspx">https://www.jointcommission.org/accreditation/nursing_care_centers.aspx</a>
American Health Care Association	<a href="https://www.ahcancal.org/quality_improvement/quality_award/Pages/default.aspx">https://www.ahcancal.org/quality_improvement/quality_award/Pages/default.aspx</a>

### 8.4 Rationale for Inclusion of Individual Measures

When considering each measure, we used the following traits as guiding rationale for selection:

1. The measure must be collected, updated, or recertified on a regular basis, and be publicly available.
2. The measure must be evidence based, as it relates to quality of care or quality of life for residents of long term care facilities, with a preference for evidence via peer-reviewed literature, or be in use in another established and validated quality rating system.
3. The measure fits one of the three aforementioned classifications.

The following subsections list the specific measures selected for use in the model and provide a brief description of the data source or program from which the measure is derived:

#### 8.4.1 Process Measures

##### 8.4.1.1 Flu Vaccine – Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine

Spread of influenza can occur between and among residents, staff, health care providers, and facility visitors. Residents of long-term care facilities can experience severe and even fatal illness during an influenza outbreak. The flu vaccine has been shown to be effective in flu prevention and the reduction of associated hospitalizations. In the event of a flu outbreak, not only is there a decrease in quality of life for the ill resident, standard precautions/procedures may significantly impede residents' quality of life including extended bed-rest, quarantine, and closure of the facility to visitors, thereby restricting access of residents to engage with family, friends and informal care networks.

##### 8.4.1.2 Antipsychotic – Percent of Residents Who Received an Antipsychotic Medication

Antipsychotic drugs are an important treatment for patients with certain mental health conditions. However, they should be used with caution, especially among older adults, as they are associated with an increased risk of death when used in elderly patients with dementia<sup>4</sup>. There is also sufficient evidence that antipsychotics are often used as chemical restraints, which increases the likelihood of falls, with or without significant injury, and can alter a resident's ability to socially engage beyond what is required to maintain health, safety and quality of life. Finally, there are ample interventions available that have proven effective for behavior management that do not require drug intervention. Higher staffing ratios, frequent and varied engagement via

<sup>4</sup> Knol W, van Marum RJ, Jansen PA, Souverein PC, Schobben AF, Egberts AC. (2009) Antipsychotic drug use and risk of pneumonia in elderly people. *Journal of the American Geriatric Society*, 56, 661–666.

activities and consistent staff assignment have all been shown to be successful in reducing utilization of antipsychotics in long term care.

#### **8.4.1.3 Restrained – Percentage of long-stay residents who were physically restrained**

Restraints are typically used to prevent someone from falling out of a bed or a chair, or limit walking. Although restraints can prevent some falls and accidents, they carry significant safety risks and directly impact the quality of life experienced by the resident. There is a lengthy history of long-term care residents who have been seriously injured while trying to escape restraints or through the use of improperly applied restraints. Residents can also become entrapped, introducing life-threatening risks, up to and including choking and suffocation. Restraints should serve as a last resort, used only when absolutely necessary as part of a medical treatment plan, and not to provide a convenience or behavior management tool for staff. A resident who is restrained can experience a host of negative health consequences, decreased independence and reduction in social contact, often leading to withdrawal, depression, anxiety and agitation<sup>5</sup>. The use of restraints additionally impedes a resident's ability to have dignity and control over basic functions. A nursing home has many options to help improve resident safety without resorting to restraints including responding quickly to resident needs (thirst, hunger, toileting), providing person-centered care, providing safe areas in which to walk or pace freely, therapy services, and adaptive equipment to ensure comfort and safety.

### **8.4.2 Outcome Measures**

#### **8.4.2.1 UTI – Percentage of long-stay residents with a urinary tract infection**

Urinary tract infections (UTI) are one of the most common infections in the long-term care setting<sup>6</sup>. Determining causation and prompt treatment of a UTI can prevent more serious complications and prevent further illness. Complications from a UTI can range and lead to hospitalization, delirium, and even render individuals comatose. Additionally, incorrect diagnosis of a UTI can lead to inappropriate antibiotic use, causing adverse effects and exacerbation of public health concerns about the increase in antibiotic resistance across care settings and recipients. Facilities can initiate interventions to help identify risk and mitigate/eliminate risk factors for UTIs. Implementing proper catheter care, toileting plans and monitoring for dehydration all are associated with decreased UTIs in long term care. This measure also promotes consistent staffing, as UTIs are often detected when the color or scent of urine changes, and/or sudden, sometimes subtle behavior and cognition changes occur, which can be more easily detected when direct care staff have high familiarity to those residents for whom they provide care.

#### **8.4.2.2 Pressure Ulcers – Percentage of high risk long-stay residents with pressure ulcers**

Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability, and can have serious consequences for the elderly, including significant pain, infection, sepsis, and mortality. Pressure ulcers are also costly and time consuming to treat, requiring enhanced provision of skilled care<sup>7</sup>. Facilities can initiate interventions to help identify risk and mitigate/eliminate risk factors, monitor the impact of interventions, and modify the interventions as appropriate based

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<sup>5</sup> Engberg, J, Castle, N & McCaffrey, D. (2007). Physical Restraint Initiation in Nursing Homes and Subsequent Resident Health. *The Gerontologist*, 48(4):442-452.

<sup>6</sup> Breitenbucher, R (1990). UTI: Managing the Most Common Nursing Home Infection. *Geriatrics*, 45(5):68-70.

<sup>7</sup> Brem, H, Maggi, J, Nierman, D, Rolnitzky, et. Al. (2010). High Cost of State IV Pressure Ulcers. *American Journal of Surgery*, 200(4): 473-477.

on the individualized needs of the resident. Improvement in resident/patient quality of care<sup>8</sup> and quality of life can be expected by following appropriate pressure ulcer prevention and treatment guidelines. Pressure ulcers can also be prevented by ensuring residents are not left chair bound or bedbound for extended periods, and are sufficiently transferred, turned and ambulated as necessary.

#### **8.4.2.3 Falls – Percentage of long-stay residents experiencing one or more falls with major injury**

Numerous studies have identified risk factors for falls within the nursing home population, including a history of falls, impaired cognitive function, postural hypotension, psychotropic and cardiovascular medications, use of restraints, balance problems during transfer and ambulation, and insomnia<sup>9</sup>. The identification of these risk factors presents a number of clinical focus areas that nursing facilities can improve or maintain to prevent and reduce incidence of falls among residents. Each year, one in every three adults age 65 and older falls. One third of falls among nursing home residents results in an injury. These injuries often lead to extended acute and sub-acute care episodes that are traumatic and costly for residents and Medicaid, and can result in long-term functional impairments or deficits. With so many factors driving the rate of facility-based falls, this measure offers a comprehensive scan of quality of care, and can drive performance in several ways.

#### **8.4.2.4 Incontinence – Percentage of low risk long-stay residents who lose control of their bowels or bladder**

Loss of bowel or bladder control is not a normal sign of aging and can often be successfully treated. Incontinence can be caused by physical and medical conditions, reactions to medication, diet or fluid intake, resident access to toilet facilities, difficulty disrobing and other factors. Many falsely view incontinence as an inevitable condition of aging, however a variety of interventions are possible if the cause of incontinence is properly identified and then managed. Individualized programs should focus on evaluation of residents to identify causes, early intervention, care planning, and early education. Increasing continence can help the well-being of the resident by restoring dignity and social interaction, reducing skin breakdown in the genital area, and improving the environmental conditions of a facility including odors<sup>10</sup>.

#### **8.4.2.5 ADLs – Percentage of long-stay residents whose need for help with daily activities has increased**

It is not uncommon for a nursing home resident to gradually lose some degree of ability to self-perform activities of daily living (ADLs) over a long-term stay. However, some late-stage ADLs can be maintained even with chronic conditions, acute illness, cognitive impairment and age related decline and frailty. These “late loss” ADLs include eating, bed mobility, transferring and toileting.<sup>11</sup> This measure tracks sudden losses in these late loss ADLs, which are not expected and would be indicative of sub-standard care, and/or an under-engagement of residents in their own ADL care, which is preferred to preserve functionality, but often ignored to facilitate ease of

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<sup>8</sup> Castle, C & Engberg, J (2005). Staff Turnover and Quality of Care in Nursing Homes. *Medical Care*, 43(6):616-626.

<sup>9</sup> Telenius, E, Engedal, K, and Bergland, A (2013). Physical Performance and Quality of Life of Nursing-Home Residents with Mild and Moderate Dementia. *International Journal of Environmental Research and Public Health* 10(20):6672-6686.

<sup>10</sup> DuBeauE., Simon, E., & Morris, N. (2006). The effect of urinary incontinence on quality of life in older nursing home residents. *Journal of the American Geriatrics Society*, 54(9), 1325-1333.

<sup>11</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1191328dl.pdf>

care or staff efficiency. This measure was also selected because the ability to perform ADLs is often a large determinant in whether a resident is able to return to a community-based setting, one of the trends the Agency has incentivized through the managed long term care plan quality standards.

### **8.4.3 Structural Measures**

#### **8.4.3.1 Direct Care Staffing (Combined) – Hours of Licensed Nursing and CNA Staffing combined**

The relationship between direct care staff and quality of life/quality of care is well established in the research and practice literature<sup>12</sup>. High RN/CNA staffing is consistently associated with better quality in nursing home care, and promotes improvement in several of the MDS long stay measures for residents<sup>13</sup>.

#### **8.4.3.2 Social Work and Activity Staff (Combined) – FTEs of Social Work or Activities Staff as defined in CMS 671 Report**

Several peer reviewed papers identified strong links between FTEs for Social Workers and Activities/Recreation Staff and quality of life<sup>14</sup>. Outcomes associated with higher staffing for Social Work and Activity include increases in personal attention received, social engagement, positive mood and overall improvement in quality of life. Recent research suggests that activity staff in particular are associated with quality of life across all domains, suggesting that social activities are as significant as physical health status.

#### **8.4.3.3 Composite and Credentialing Measures**

Also included in this model as structural measures, are one composite measure and three credentialing measures. As each of these measures comprise several different facets, each will be described separately along with a rationale for inclusion in the Florida NPPS Quality Incentive Program.

#### **8.4.3.4 CMS 5 Star Rating**

The CMS 5 Star is the federal quality rating system created by CMS to help consumers select and compare skilled nursing facilities. Every facility that receives Medicare/Medicaid reimbursement receives a rating.

There are three components to the Five Star Rating system, resulting in three separate ratings compiled into one overall one to five-star score:

- **Health Inspections:** Each facility's previous three years of State Health Inspection scores are averaged with increased weight on the most recent year's score.
- **Staffing:** The staffing hours amongst RNs and the total nursing staff are case mix adjusted to determine an average ratio of staffing hours to resident days.

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<sup>12</sup> Spilsbury, K., Hewitt, C., Stirk, L., & Bowman, C. (2011). The relationship between nurse staffing and quality of care in nursing homes: a systematic review. *International journal of nursing studies*, 48(6), 732-750.

<sup>13</sup> Hung, P, Casey, M and Moscovice, I (2015). Nurse Staffing Levels and Quality of Care in Rural Nursing Homes. Univ of Minnesota Rural Health Research Center. Policy Brief, January 2015.

<sup>14</sup> Degenholtz, H. B., Kane, R. A., Kane, R. L., Bershadsky, B., & Kling, K. C. (2006). Predicting nursing facility residents' quality of life using external indicators. *Health services research*, 41(2), 335-356.

- **Quality Measures (QM):** There are 16 measures split between short term and long-term stays, including:

Short Term Stay:

1. Percentage of residents who self-report moderate to severe pain
2. Percentage of residents with pressure ulcers that are new or worsened
3. Percentage of residents who are newly administered antipsychotic medications
4. Percentage of residents who have had an outpatient Emergency Room visit
5. Percentage of residents who were successfully discharged to the community, and did not die or were readmitted to a hospital or skilled nursing facility within 30 days of discharge
6. Percentage of residents who were re-hospitalized after SNF admission, including observation stays
7. Percentage of residents who made improvement in physical function and locomotion

Long Term Stay:

8. Percentage of residents whose need for help with activities of daily living has increased
9. Percentage of high risk residents with pressure ulcers
10. Percentage of residents who have/had a catheter inserted and left in their bladder
11. Percentage of residents who were physically restrained
12. Percentage of residents with a urinary tract infection
13. Percentage of residents who self-report moderate to severe pain
14. Percentage of residents experiencing one or more falls with major injury
15. Percentage of residents who received an antipsychotic medication
16. Percentage of residents whose ability to move independently worsened

Quality Measure data for the MDS-based QMs and the nursing home QM ratings are updated on a quarterly basis. The updates occur mid-month in January, April, July, and October. The claims-based QM data will update every six months (in April and October). Changes in the quality measures may change the star rating (CMS August 2016).

There is no cost to participate in the CMS 5 Star Rating Program.

#### **8.4.3.5 Florida Governor's Gold Seal**

The Gold Seal Program recognizes nursing facilities that demonstrate excellence in long-term care. The award is made by the Governor's Panel on Excellence in Long Term Care. The Gold Seal Award program is not mandatory for providers. Recipients are identified publicly on the Florida Health Finder data base for nursing homes. The Gold Seal Award includes several required components in order to be awarded a Gold Seal, as determined by the selection panel:

1. Regulatory history – the facility must be operational for at least 30 months prior to award, with no class I or II deficiencies in the previous 30 months
2. Financial Soundness and Stability, established by AHCA rule
3. Evidence of Consumer Satisfaction
4. Evidence of Community/Family Involvement
5. Workforce Stability/Turnover
6. Demonstration of targeted in-services around quality improvement, identified internally or externally.

To be considered for a Gold Seal Award, the facility's quality of care rank must be in the top 15 percent of facilities in the applicant's region or top 10 percent of facilities statewide. The facility must also be ranked in the Nursing Home Guide as a five-star facility. Onsite visits are not required to be eligible for the award.

Data is compiled from multiple sources including unannounced State Inspections conducted by objective professional multidisciplinary teams with oversight by state and federal agencies using state and national standards and protocols. Information is also provided for financial soundness, turnover rates and evidence of community/family involvement.

The Gold Seal Award must be renewed every 3 years. There are numerous provisions for termination of Gold Seal status.

There is no cost to participate in the Florida Gold Seal Award.

#### **8.4.3.6 Joint Commission Accreditation**

The Joint Commission's accreditation process seeks to help organizations identify and resolve problems, and to inspire them to improve the safety and quality of care, treatment, and services.

Joint Commission Accreditation for Nursing Home Care standards focus on care and organizational functions that are essential to providing safe, high quality care. Standards are developed in consultation with long term care experts, providers, measurement experts, patients, and their families. Among the standards for long term care are those listed in the following figure:

Figure 19. Long term care standards reviewed as part of the Joint Commission accreditation.

<b>Record of Care</b>	<b>Rights and Responsibilities of the Individual</b>
Emergency Management	Environment of Care
Human Resources	Treatment and Services
Infection Prevention and Control	Performance Improvement
Leadership	Provision of Care
Life Safety	
Medication Management	
National Patient Safety Goals	

Accreditation requires an onsite survey, performed by the Joint Commission every three years. Surveys are conducted by experienced long term care professionals who have at least five years of leadership experience in a long term care facility and a strong educational background. Surveyors are required to complete and pass a surveyor certification examination, to ensure consistency across The Joint Commission's survey process.

Joint Commission surveys are generally unannounced. A survey is designed to be individualized to each organization, to be consistent, and to support the organization's efforts to



improve performance. During the on-site survey, Joint Commission surveyors evaluate an organization's performance of functions and processes aimed at continuously improving patient outcomes.

While onsite, surveyors track the care delivered to residents, reviewing information and documentation provided by the facility while observing and interviewing staff and residents.

Although an on-site survey is required every 3 years, facilities must also participate in an "Intra-cycle Monitoring Process" (ICM) in order to maintain accreditation. The ICM helps organizations with their continuous standards compliance effort. The Joint Commission requires all accredited organizations to acknowledge annual standards through self-assessment activities during the intervening years between on-site full survey events (at 12 and 24 months of the triennial general accreditation cycle).

The onsite survey fee for a nursing home choosing accreditation with an average census of 100-119 residents is \$3,215, and the annual fee is \$2,170. A nursing home of the same size electing the Medicare/Medicaid accreditation option would pay a similar total amount, but some would be paid to Medicare and some would be paid to the Joint Commission.

#### **8.4.3.7 AHCA National Quality Award**

The American Health Care Association (AHCA) / National Association for Assisted Living (NCAL) National Quality Award is based on the Baldrige National Quality Program, a performance improvement program initially created to help improve competitiveness of American companies. Affiliated programs use the Baldrige Excellence Framework to advance organizational excellence.

The AHCA/NCAL National Quality Award Program provides a framework for providers of long term care services to follow for performance improvement. The Baldrige framework emphasizes a fact-based, knowledge-driven system for improving performance and competitiveness, utilizing comparative data from other similar organizations (local, regional, or national) to continuously drive quality improvement and competitiveness. The Baldrige framework approaches quality management through seven different, but interconnected categories:

1. Leadership - Creating & Sustaining an Environment for Excellence
2. Strategic Planning - Developing Strategic Objectives and Action Plans for Competitive Advantage
3. Customer Focus - Understanding Your Customers
4. Measurement, analysis and knowledge management - Managing by Fact to Drive Performance Improvement
5. Workforce - Developing and Realizing the Full Potential of Your Workforce
6. Operations - Designing Work Systems to Deliver Customer Value
7. Results - Tracking and Using Key Results

The AHCA NQA has 3 levels of award: Bronze, Silver and Gold, with Gold being the highest level. The AHCA NQA is recognized as a Baldrige "top tier" award program and Gold recipients can go on to apply for the Baldrige award.

Applicants pursuing the Bronze must show a level of commitment to quality. The facility is assessed by their ability to describe the links between their mission, key customers and strategic position and to show evidence of successful performance improvement. The goal of

this award level is to provide applicants with the tools and resources they need to achieve performance improvement.

Silver level applicants provide an extensive self-assessment based on the 7 key categories of the Baldrige Framework. Applicants describe their approaches to and deployment of quality improvement. Applicants must provide a complete organizational profile and provide at least two performance measures for each of the five Criteria for Performance Excellence. Measures must be responsive to the category, show at least 3 historical data points trending in a favorable direction, show that performance is at or better than comparable organizations/industries, and be segmented in such a way that allows for meaningful analysis of the organization's performance.

Silver and Gold applications are reviewed by volunteer Senior Examiners and Master Examiners, respectively. Evaluation teams use a formal process established by AHCA/NCAL; Gold applicants may be considered for a site visit. Master Examiners may also be asked to conduct a Site Visit at a Gold applicant organization to verify and clarify strengths and opportunities found within the application.

Silver awardees must apply for the Gold award within 3 years and not get the application disqualified in order to retain award level. Gold recipients will be considered a recipient in the year they received the award. After 5 years, Gold recipients must reapply for certification and may reapply at the Bronze, Silver or Gold level. However, once they choose an award level, they are subject to the policies of that level.

The cost to providers for achieving these awards can range from \$950 to \$2,800, depending on the level of the award, and the method used to apply for the award. Applicants must be members of AHCA in order to apply. Non-members may choose to apply for the Florida Sterling Award or the Baldrige National Quality Program and pay the associated fees. The national program does not have the Bronze or Silver levels of the award.

## **APPENDIX C**

### 2016 Nursing Facility Payment Recommendations Report, Frequency of Rebasing Under Prospective Payments Excerpt

#### **9.2 Rate Setting Timing and Frequency**

##### **9.2.1 Discussion**

The recommended Medicaid prospective payment system generally employs a modified pricing system which combines aspects of a price based system with the principles of a cost-based system. The direct, indirect and operation components utilize portions of both systems by setting the respective rate components for all facilities at a value that is based on a percentage of the median cost per day values of all providers and with a predetermined floor for the direct and indirect components (described earlier). The total per diem is calculated as the sum of the direct care, indirect care, operations/administration, nursing facility provider assessment, pass through property taxes and insurance, fair rental value and quality incentive. AHCA has several options for rebasing each of these components. Navigant recommends several of these components be rebased annually, while others should be rebased every three years.

##### **9.2.2 Recommendation**

###### **9.2.2.1 Direct, Indirect and Operation Costs**

Under the new reimbursement methodology, the direct care, indirect care and operation per diem values are calculated based upon the cost reports submitted to AHCA prior to the 2016 rate year. Navigant recommends these components be rebased at the end of the 3rd fiscal year using newer cost and patient utilization information as reported in the latest applicable cost report. Specific dates for rebasing will be determined once the system implementation date is determined. Pursuant to budget availability, and at AHCA's discretion, Navigant recommends that these component rates for intervening years receive an inflation factor to adjust for cost changes in healthcare delivery.

###### **9.2.2.2 Cost Reports**

In collaboration with AHCA, we are recommending that nursing facilities continue to submit Medicaid cost reports annually and that audited cost reports be used in the rate rebasing process performed once every three years. Using audited cost reports will ensure accuracy of the data used to determine the median costs for each per diem component and will ensure that the adjustment in individual facility rates based on per diem floors is applied accurately. To enable use of audited cost reports in rebasing once every three years, AHCA would need to audit every nursing facilities' cost reports at least once every three years (currently AHCA audits cost reports at least once every five years). In addition, the amount of inflation applied to facility cost would have to vary by facility depending on the timing of the most recently audited cost report.

With cost reports being submitted annually, cost reports could also be modified to be used as the vehicle for communicating facility renovation information in the future. In addition, the cost report audit process should be expanded to review renovation information and facility square footage (used in the FRVS calculations).

###### **9.2.2.3 Fair Rental Value System**

A fair rental value system is used to reimburse property costs. This system reduces the wide disparity in costs for property payments, paying a fair rate of return on the value of the property, thus making the payments more equitable for all providers. The FRVS is used in lieu of actual allowable costs associated with the land, building, equipment, etc. applied for resident care.

Navigant recommends that the FRVS be rebased annually to reflect and capture adjustments to the RSMMeans values per square foot and any adjustments to the age of the facility (for depreciation purposes) attributable to major renovations (discussed earlier). For renovations that meet the criteria of a “major renovation” (at least \$500 per facility bed), the reduction to the building age will be calculated with the FRVS for the following fiscal year.

Pass through payments for property-related taxes and insurance are reimbursed based on facility-specific reported costs. Navigant recommends reimbursing the costs for property-related taxes and insurance annually using actual historic cost and patient days as shown in the latest applicable cost report.

#### **9.2.2.4 Quality Incentive Model**

In addition to the rate components described above, a quality incentive enhancement will be added to the rates for high performing facilities. High performing facilities are defined as those exceeding the 30<sup>th</sup> percentile for the quality score.

Navigant recommends recalculating all elements of the Quality Incentive score for each facility annually. At the same time, we recommend freezing the benchmarks for the Process and Outcome measures in the interim years between rebasing periods. Freezing the benchmarks for a period of time allows lower performing facilities to see finite benchmarks they can strive to attain as opposed to benchmarks that are recalculated annually, thus making them moving targets. When rebasing does occur, possibly once every three years, the benchmarks should be updated based on the MDS Quality Measures accessible from data.medicare.gov. Quality improvement percentages are calculated based on the percent change from the previous fiscal year to the appropriate quarter of the current year. Thus, points for quality improvement should be recalculated annually.<sup>15</sup>

Navigant further recommends updating the benchmarks for the Direct Care Staffing (RN, LPN, CNA) and Social Work/Activity Staff hours annually. These measures are currently calculated from data reported in nursing facility cost reports and the CMS 671 reports, respectively. The CMS Five Star rating should be updated annually using the most recent overall rating from data.medicare.gov. Similarly, the Florida Gold Seal, AHCA/NCAL National Quality Award and Joint Commission Accreditations should be updated annually and are accessible through the respective websites.

We also recommend keeping the reimbursement amount per quality point constant for each year included between rebasing periods. In our current models, this amount is slightly less than \$1.32 per quality point per resident day. This will avoid diluting the value of quality points as facilities continue to improve quality and raise their quality scores. However to allow the reimbursement per quality point to remain constant, the total sum of funds distributed through the Quality Incentive Program would increase slightly each year. This could be afforded via a variety of methods including,

- Applying annual inflation, if legislatively appropriated, to the Quality Incentive Program first, before applying it to other components of the per diem
- Building an increase in the Quality Incentive Program funds into annual budget estimations
- Shift slightly more funds from other per diem components into the Quality component each year

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<sup>15</sup> Percentile scores are calculated using the 4<sup>th</sup> quarter scores and segmenting to appropriate percentile.

## APPENDIX D

### 2016 Nursing Facility Payment Recommendations Report, Budget Neutrality Excerpt

#### 7.4 Budget Neutrality

##### 7.4.1 Discussion

Legislative direction for this study clearly states that the recommendations for the new method should be designed in a “budget neutral manner.” We interpreted the budget neutrality requirement to apply to the overall budget for the Medicaid nursing facility program, and not a requirement for budget neutrality by facility. In addition, we assumed this requirement allowed for redistribution of funds within current components of the per diem and to new components of the per diem, most notably the Quality Incentive Program.

##### 7.4.2 Recommendation

Through discussions with the AHCA Governance Committee and industry stakeholders, we decided to maintain budget neutrality separately for the property and for the non-property components of the per diem. Within the property component, we chose to continue including the funds currently distributed as pass through payments for home office property costs. Our models include current reimbursement for home office property costs in the total budget available for determination of the new Fair Rental Value System (FRVS) payment parameters (see section 7.8.2 for more detail on this topic). Other existing pass through payments, specifically property tax and property insurance, are included in our models in a budget neutral manner as stand-alone payments separate from our FRVS calculations (see section 7.9 for more detail on pass through payments in our proposed new payment method). In addition, facility-specific budget neutrality was maintained for the nursing facility provider assessment portion of the per diem.

The Quality Incentive Program was funded first with the funds currently identified as Operations add-on payments, which come from “surplus” funds from the nursing facility quality assessment program. These funds total approximately \$130.5 million. The rest of the funds for the Quality Incentive Program, \$86.4 million, came from a reduction in funds for the non-property per diem components – Direct Care, Indirect Care, and Operations.

Funds for service specific add-on payments (for ventilator care) also came out of the budget for the non-property components of the final per diems. The resulting estimated Medicaid spend<sup>16</sup> by per diem component for residents and facilities included in the new NPPS is shown in Figure 8 below.

**Figure 8. Medicaid targeted spend by per diem component.**

New Payment Method	Budget in New Payment Method
Non-Property (sum of Direct Care, Indirect Care, and Operations)	\$2,873,320,011
Nursing facility provider assessment	\$268,171,011
Property component (includes payments for home office property costs)	\$174,115,050
Pass through payments for property taxes and property insurance	\$46,892,799
Quality incentive program	\$216,884,906
Add-on payments for ventilator care	\$8,150,881
<b>Total</b>	<b>\$3,587,534,658</b>

<sup>16</sup> This total spend is calculated using the number of annualized Medicaid days reported in nursing facility cost reports.

## APPENDIX E

### 2016 Nursing Facility Payment Recommendations Report, New Facilities Excerpt

#### 9.2.2.5 New Facilities

A provisional rate will be paid to a provider who constructs a new facility. For the Direct Care, Indirect Care and Operations portions of the per diem, the provisional rate will be the standard per diem for facilities in the same peer group. No per diem floor will be applied. This will be true until an initial cost report is received by AHCA. The FRVS, property taxes and insurance pass through payments will be determined from information reported in the facility's budgeted cost report. Quality Incentive payments will be applied at a value equal to the 50<sup>th</sup> percentile quality score calculated for all facilities in Florida. Ventilator care add-on payments will be based on the number of ventilator beds and the minimum occupancy estimation.

The initial cost report will affect rates for the facility until rates can be updated with results of an audited cost report.

For the first year of operation, we recommend the minimum occupancy value to be used in the FRVS calculation be 75 percent, and then increase to the standard value in all subsequent years. This is consistent with current AHCA policy related to the property per diem component, which states,

"... for providers with newly constructed facilities, the provider's per diem calculated for that facility's first year of operation shall be the result of the principal and interest or interest-only expense divided by 75 percent of the maximum possible annual bed days."<sup>17</sup>

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<sup>17</sup> Florida Medicaid State Plan, Attachment 4.19-D – Long Term Care Reimbursement, effective July 1, 2015.

## **APPENDIX F**

### 2016 Nursing Facility Payment Recommendations Report, Timeliness of Audits and Desk Reviews Excerpt

#### **9.2.2.2 Cost Reports**

In collaboration with AHCA, we are recommending that nursing facilities continue to submit Medicaid cost reports annually and that audited cost reports be used in the rate rebasing process performed once every three years. Using audited cost reports will ensure accuracy of the data used to determine the median costs for each per diem component and will ensure that the adjustment in individual facility rates based on per diem floors is applied accurately. To enable use of audited cost reports in rebasing once every three years, AHCA would need to audit every nursing facilities' cost reports at least once every three years (currently AHCA audits cost reports at least once every five years). In addition, the amount of inflation applied to facility cost would have to vary by facility depending on the timing of the most recently audited cost report.

With cost reports being submitted annually, cost reports could also be modified to be used as the vehicle for communicating facility renovation information in the future. In addition, the cost report audit process should be expanded to review renovation information and facility square footage (used in the FRVS calculations).

## **APPENDIX G**

2016 Nursing Facility Payment Recommendations Report, Exempt Providers Excerpt

### **9.2.2.7 Pediatric Provider and Veterans' Nursing Home Carve Outs**

As mentioned previously, we are recommending that care for children in nursing facilities and Veterans' nursing facilities be carved out of the NPPS payment methodology and instead be paid under a system similar to what is currently in use, however, with payments paid prospectively. To enable prospective payment, rates should be set based on audited cost reports inflated to apply to the rate year. For facilities that care for both adult and pediatric residents, separate cost reports should be developed for the adult and pediatric portions of their business. Only the pediatric portion will continue to be reimbursed on facility-specific cost-based rates. Rates for these carved-out services and providers can be updated annually.

In addition, in collaboration with AHCA, we recommend that the Property portion of the per diem for all of the facilities carved out of the full NPPS shift to be calculated using the new FRVS method included as a component of the new NPPS. The new FRVS calculation for the Property per diem component is significantly less complicated than the current FRVS calculation.



# APPENDIX H

## Alternative Proposal for FL Quality Incentive Payment Pool Quality Measures

Provider Performance Measures	Performance Benchmark					Max. Score	Improvement Benchmark			Max. Score	Notes
	Low		Med		High		Low	Med	High		
Percentage of long-stay low-risk residents who lose control of their bowels or bladder	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	FL performs worse than national avg; FL 53.2% vs 47.4% Natl
Percentage of long-stay residents who got an anti-anxiety or hypnotic medication	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	FL performs worse than national avg. FL average is 27.1% of residents compared to 23.1% National average
Percentage of long-stay residents who got an antipsychotic medication	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	FL performs better than national average, 15.7% FL vs 16.1% national
Percentage of long-stay high-risk residents with pressure ulcers	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	FL performs slightly worse than national avg; 5.9% FL vs 5.7% Natl
Percentage of long stay residents experiencing one or more falls with major injury in the past 12 months	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	FL performs better than national average, 2.8% FL vs 3.4% national
Direct Care Staff Turnover in the past 12 months	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	
Percentage of residents that have consistent staff assigned to them on each shift	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	5% improvement over prior year	10% improvement over prior year	15% or greater improvement over prior year	3	
Combined Direct Care Staffing hours per resident day	50th percentile (3 points)	60th percentile (4.5 points)	70th percentile (6 points)	80th percentile (7.5 points)	90th percentile (9 points)	9	2% or greater improvement over prior year	4% or greater improvement over prior year	6% or greater improvement over prior year	3	
Certified Nurse Aide hours per resident day	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	2% or greater improvement over prior year	4% or greater improvement over prior year	6% or greater improvement over prior year	3	
Care Ratio (Direct & Indirect Care Expenditures/Total Revenue)	50th percentile (1 point)	60th percentile (2 points)	70th percentile (3 points)	80th percentile (4 points)	90th percentile (5 points)	5	2% or greater improvement over prior year	4% or greater improvement over prior year	6% or greater improvement over prior year	3	
Medicaid Occupancy for SNFs		60th percentile (1 point)	70th percentile (2 points)	80th percentile (3 points)	90th percentile (4 points)	4	2% or greater improvement over prior year	4% or greater improvement over prior year	6% or greater improvement over prior year	3	Given that only 80% of facilities will actually receive the Quality Incentive payments, facilities that treat a disproportionate amount of Medicaid residents should be awarded additional points to put them on a potential level playing field with facilities that have more resources from Medicare and private pay patients.
CMS 5 Star Rating			3 stars (1 point)	4 Stars (3 points)	5 Stars (5 points)	5				N/A	
Quality Care Committee	Nursing Facility has at least one joint employer-employee or labor-management committee that meets at least quarterly, with equal participation of both frontline caregivers (or their representatives) and management, with a committee mandate that includes review of workers safety, staffing guidelines, and quality of care. (4 points if have a committee, 0 points if do not)					4				N/A	
Total per Component						67				33	
<b>Total score (Performance + Improvement)</b>		<b>100</b>									

A stakeholder committee should reexamine the quality measures every 2 years.

Nursing facilities that do not meet the current staffing minimum requirements should not be eligible for the quality incentive payments

Facilities with higher scores will receive a higher Quality Incentive payment

