1199SEIU UHWE Florida Prospective Payment Recommendations

1199SEIU United Healthcare Workers East is the largest healthcare union in the nation. 1199SEIU UHWE represents healthcare workers in Florida, the District of Columbia, Maryland, Massachusetts, New Jersey, and New York - with 400,000 members representing every part of the healthcare industry - including home care, hospital, nursing homes, and outpatient facilities. In Florida, we represent over 28,000 healthcare workers.

As frontline caregivers, 1199SEIU UHWE members see how changes to reimbursement and regulation impact our residents’ everyday lives. A change from the current cost based reimbursement methodology with a retrospective adjustment to a prospective payment system should ensure that the new methodology does not result in a race to the bottom amongst facility operators in order to be profitable, which negatively impacts residents and frontline caregivers. Numerous studies have shown that the direct care workforce is intimately linked to the quality of care provided in nursing homes. Any change to reimbursement that attempts to control costs through decreasing the direct care that nursing home residents rely on for their daily needs would be antithetical to promoting quality patient care.

In developing recommendations for the new prospective payment methodology 1199SEIU UHWE evaluated models using the following guiding principles:

- Direct Care Staff are central to ensuring high quality care for Florida’s Medicaid beneficiaries.
- The impact of any changes to reimbursement systems should seek to have neutral or positive impacts on retention, wages, and staff development.
- Quality incentives should have sound, consistent methodology that is reflective of the best quality of care.
- Appropriate reimbursement is necessary for ensuring nursing home quality.

Price Based Reimbursement for Labor Costs Will Negatively Impact Quality Care

1199SEIU UHWE recommends a cost based reimbursement system to minimize impacts of operational disruption on resident care from transitioning to a prospective payment system. A price based reimbursement for direct care labor costs is inappropriate as it will negatively impact the quality of care in Florida nursing homes. While it may be appropriate to compete on costs using a price based reimbursement for certain costs - such as toilet paper - a price based reimbursement that drives down wages and staffing levels stands in direct opposition to numerous studies showing that direct care staff have a significant impact on the quality of care in nursing homes. Specifically, studies have shown that continuity of care, staff retention, longevity and development are all critical to ensuring quality nursing home care. A price based methodology incentivizes providers to compete for the lowest cost staff and the minimum staffing levels rather than the most qualified direct care workforce. This incentive would have direct deleterious effects on nursing home quality statewide.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), 36 states use a cost-based reimbursement methodology for nursing facilities’ direct care costs, with most state having a reimbursement ceiling to assist with controlling costs. Generally the facility
receives the lower of either their actual costs or the direct care cost center ceiling rate. The cost center ceiling varies from a percentage of the median cost (e.g. 135% of the median) or a percentile (e.g. 90th percentile) of a group of facilities per diem cost. Currently Florida uses a reimbursement ceiling for direct resident care costs of the statewide direct care median plus a 1.75 standard deviation adjusted by the ratio of the class medians to the statewide median. We recommend using a simpler methodology, such as the 90th percentile of direct care costs of the class or peer group.

For example, Georgia reimburses routine services, which includes direct care labor costs, up to the 90th percentile of the routine services per net diem. Tennessee and Oklahoma also reimburse for the direct care cost component up to the 90th percentile.

**New PPS System Should Protect Providers with High Medicaid Caseloads**

Florida nursing homes are charged with caring for some of the most vulnerable members of our society. A new reimbursement system must ensure that facilities with significant Medicaid caseloads remain financially viable. We recommend that the Medicaid Adjustment Rate remain in place, or that AHCA use an alternative adjustment for high Medicaid caseload facilities.

**Reimbursement Should Reward Quality Care**

A robust quality incentive program should use a consistent methodology and be grounded in academic research. Direct care staff are at the heart of daily life in a nursing home, and there is strong evidence connecting higher staffing with greater quality of care. Staffing metrics will establish that facilities have the human resources necessary to provide quality care and should be paired with quality metrics to measure outcomes. Specifically, quality incentives should reflect: staffing levels for direct care staff (RNs, LPNs, and CNAs); staff retention of direct care staff; staff training; the use of consistent assignment; labor management programs; and quality measures. Such staffing related measures have been used in some states value based purchasing programs, such as Minnesota, Kansas, Ohio, Iowa, Georgia, Oklahoma. Also, the quality incentive program should factor in both achievement and improvement on quality measures, which is proposed by CMS for the Medicare SNF value based purchasing program and as currently exists in the CMS Medicare hospital value based purchasing incentive program.

1199SEIU UHWE recommends that the following be included in the quality component of a new prospective payment system:

- **Staffing Levels above State Median**: Facilities should be evaluated on their performance relative to the state median in RN hours per resident day, LPN hours per resident day, and CNA hours per resident day.
- **Staffing Levels above National Median**: Facilities should be evaluated on their performance relative to the national median in RN hours per resident day, LPN hours per resident day, and CNA hours per resident day.
- **Staff Stability**: Facilities should be evaluated on their performance relative to state median in RN, LPN, and CNA retention.
- **Consistent Assignment**: Facilities should be evaluated on their practice in consistently assigning direct care staff to residents as defined by Advancing Excellence.
- **Staff Training**: Facilities should be incentivized to conduct staff training, with a particular focus on labor-management programs that involve direct care staff in curriculum development.

- **Staff Wages and Benefits**: Facilities should be incentivized to compensate facility staff with living wages and provide affordable health insurance, and can be evaluated by the percentage of facility staff that are earning at or above area living wage standards.

- **Ownership Continuity**: Quality components should incentivize long-term, stable nursing home owners who will invest in their facility, workforce and quality of care.

- **Quality Measures**: Facilities should be evaluated on their performance on MDS 3.0 quality measures for long-stay and short-stay residents, using raw data – rather than star composites – to measure quality outcomes.

- **Health Inspections**: Facilities should be evaluated on their performance relative to state and national averages on health inspections using both standard surveys and complaint surveys that have been conducted at the facility over the last three years.

- **Exclude Third-Party Quality Assessments**: Facilities should be evaluated using the above-referenced metrics, which - through raw data and primary sources - provide a unified and simple, and easy to replicate methodology. AHCA should not use third-party assessments (e.g. JCAHO Accreditation; Baldridge Criteria) as it unnecessarily complicates the rate setting methodology and only serves as a stand-in for the primary source data referenced above.

**Keep Capital Costs Segregated from Operating Costs**
Consistent with prioritizing quality, the prospective payment system should keep property costs segregated from all other direct and indirect operating cost components. Given the mandate of budget neutrality, the new payment system should guarantee funds related direct care and operating costs are not used for property costs or campus enhancements.

If a Fair Rental Value System is adopted, we encourage that other states models besides Georgia and North Carolina are considered, such as California which includes an aggregate growth cap of 8% on FRVS costs compared to the previous year. Additionally, the variables that are used, such as average room square footage, equipment costs, and rental factor should be set at levels that are reasonable and do not result in major increases in the capital cost component to the detriment of direct and indirect resident care.

**New Payment Systems Should Continue to Foster Reimbursement Accountability**
We recommend that the Agency for Health Care Administration continue their robust cost reporting system, even as changes to the reimbursement system are implemented. Nursing homes are largely funded by public dollars, and transparency in financial reporting is essential to public accountability. Additionally, a robust auditing procedure should be instituted to ensure that reimbursement funds are spent on their intended purposes, especially direct care and indirect care cost center reimbursement. For example, one method is to require all facilities be subject to a full-scope audit at least once every 3 years and any discovered overpayments shall be recouped by the state.
Minimize Operational Disruption through Reimbursement Transition
A phase in period will allow providers to adjust to changes with the least disruption to daily operations. 1199SEIU UHWE supports a multi-year phase-in period of the new rate methodology for all providers, with the current rate comprising the bulk of the rate in year 1, a composite of the new and old rates during the transition years, and finally a full transition to the new rate occurring after a multi-year timeline.