Nursing Facility Payment Review and Redesign

Building Block #2: Quality (Week 1)

10.22.2020

Today's Agenda

- Overview and recap of Week 3
  - Corrected data and interpretation
- Questions and brief comment
- Quality Week 1
  - STAR ratings
  - Considerations in developing ratings
- Questions and brief comment on today's content
- Next steps and request for content

Purpose Statement

HFS proposes a structured and transparent approach to develop, deliberate, adopt and implement nursing home payments to achieve improved outcomes and increased accountability with an emphasis on patient-centered care. HFS believes the rate mechanism, funding model, assessment, quality metrics, and staffing requirements can and should be updated in conjunction with any new or additional appropriated funding. Further, additional federal funding should be captured to improve these areas through an increase in the current nursing home bed tax.

Steps in the Review and Redesign Process

Building blocks in a comprehensive NF payment:

- Staffing (3 meetings)
- Quality (2 meetings)
- Physical Infrastructure
- Rebalancing
- Capacity (facilities and staffing)
- Case Mix, Equity and Demographics
- Modeling (multiple meetings)

Note: COVID has had a profound impact on long term care. Infection control is assumed to be an integral component of each building block.

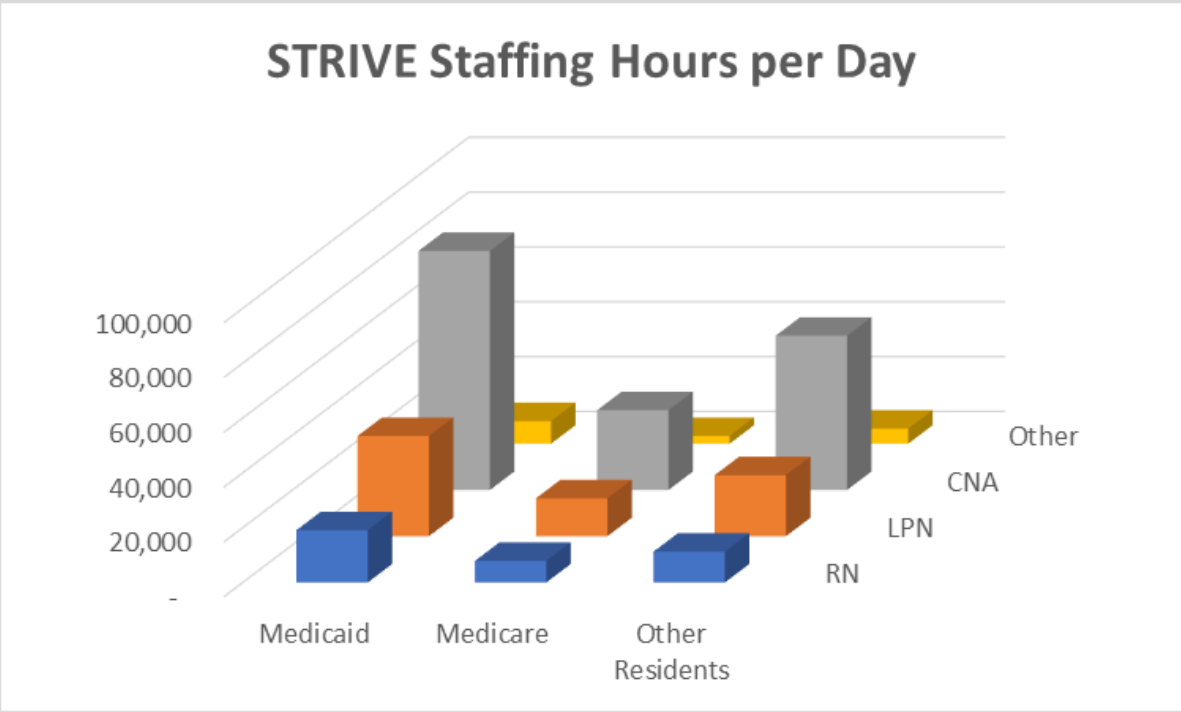
Original Objectives and Principles for Reform

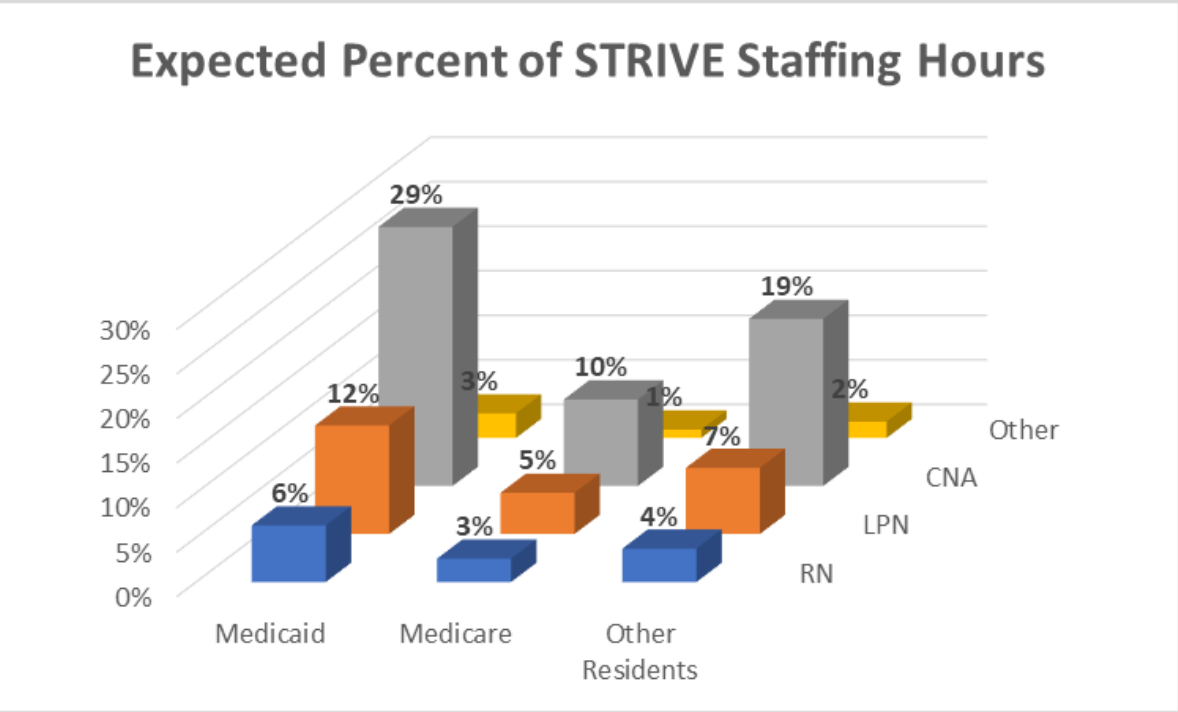
Potentially Relevant to Today's Discussion on Quality:

- **Transparent, outcome driven, patient-centered model with increased accountability**
- Transition away from RUGS to federal PDPM case-mix nursing component
- Modify the support and capital rate into a set base rate similar to Medicare non-case-mix rate
- End the $1.50 bed fee and increase the occupied bed assessment to create a single assessment program which maximizes federal revenue
- **Directly tie funding/rates/incentives to demonstrable and sustained performance on key quality reporting metrics**
- **Documentation to support, review and validation of level of care coding and appropriateness, outliers, actual patient experiences, etc.**
- **Align regulation and payment incentives to the same goals**
- **Ensure appropriate incentives for community placement, including both uniform and MCO-specific incentives**
- Recalibrate/rethink payment for nursing home infrastructure to support emerging vision for the industry in the wake of the COVID-19 crisis, including single-occupancy rooms, certified facilities
- Integrate emerging lessons and federal reforms related to the COVID pandemic
- Improved cooperation, support and follow up, data sharing and cross-agency training from other agencies (OIG, IDPH, DoA)
- **Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes**

Hypothetical STRIVE-Based Staffing Hours by Payer

MDS 4Q 2019; All Direct Care Staff Time



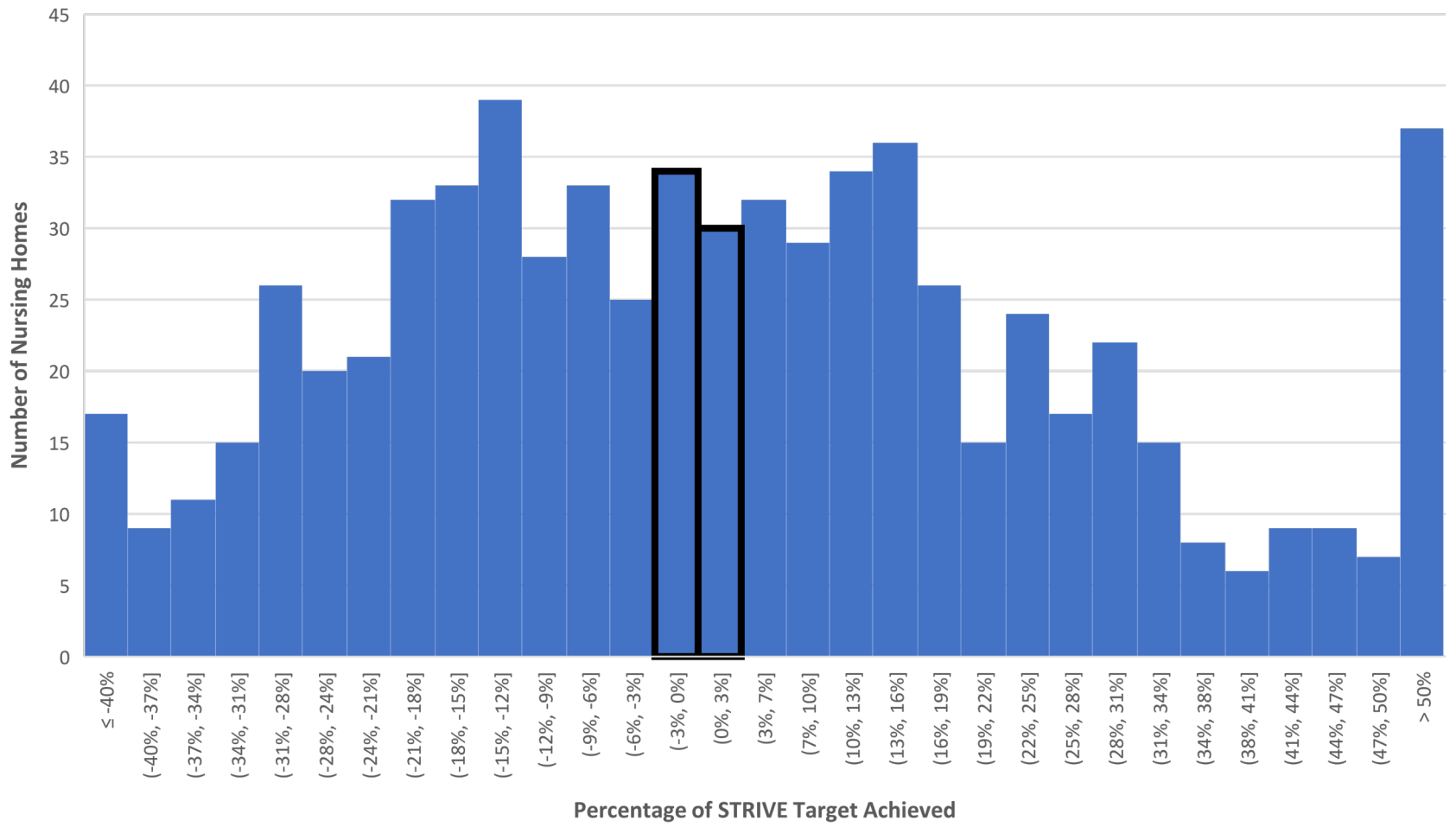


Notes:

- Staff time by payer and resident is not tracked and recorded. These allocations are a hypothetical characterization for illustrative purposes only.
- Other Staff include Cert. Med. Aide, Restor. Aide, Bath Aide, Feeding Aide, Psych Aide, Non Cert. Care Tech, Clin. Assoc., & Transportation Resp. Ther. Asst.

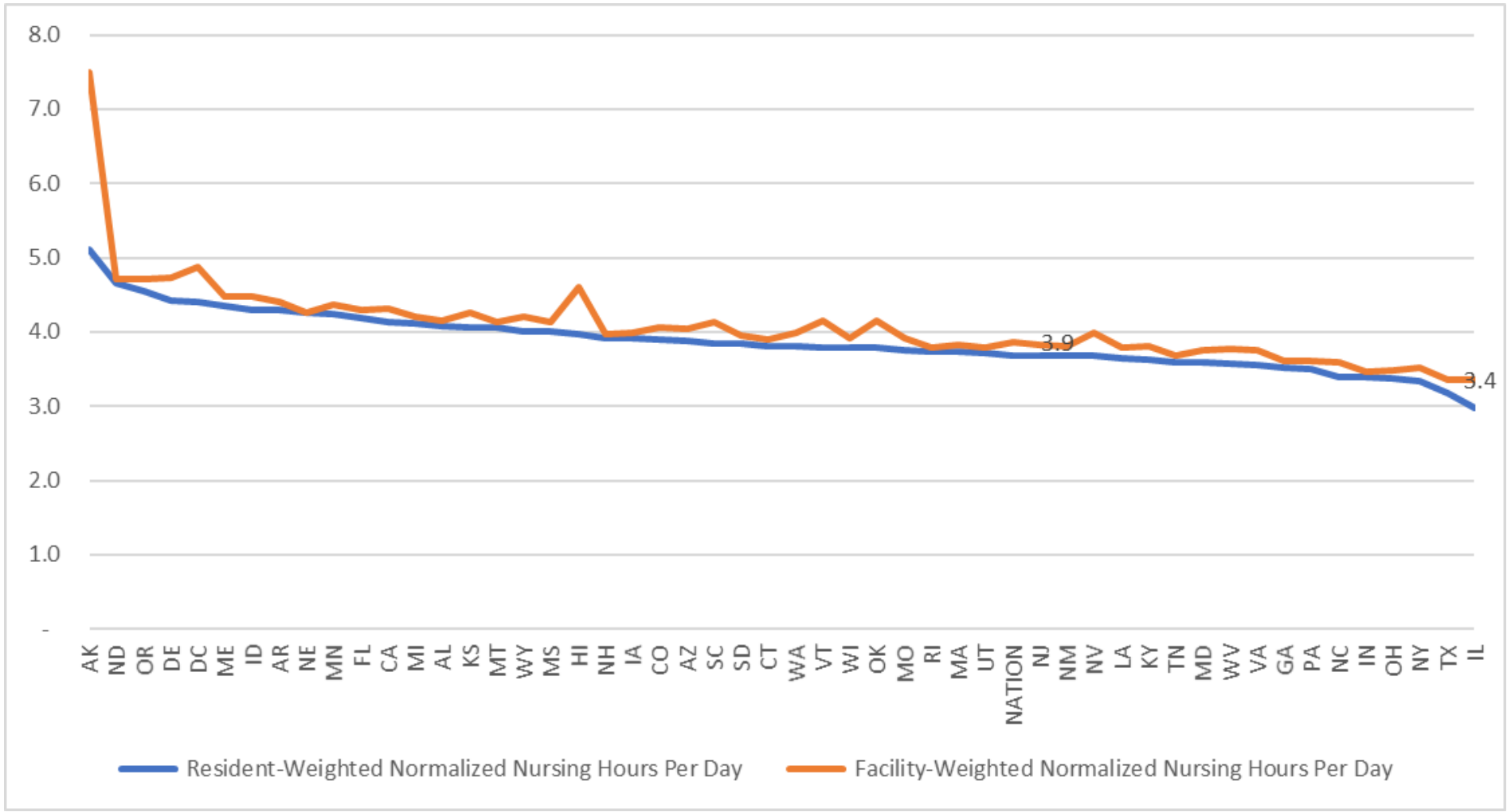
Distribution of Illinois SNFs by % of STRIVE Staffing Target

(MDS case-mix adjusted; source 4Q2019 PBJ)



SNF staffing levels vary widely in Illinois and are not concentrated around STRIVE targets.

State Rankings for Nurse Staffing Ratios
(Nationally normed; Medicare COMPARE Provider Info 10.21.2020)



Illinois is at the bottom of the resident-weighted national rankings
and second from the bottom in facility-weighted rank

The difference between the two metrics may reflect generally lower staffing ratios in large facilities

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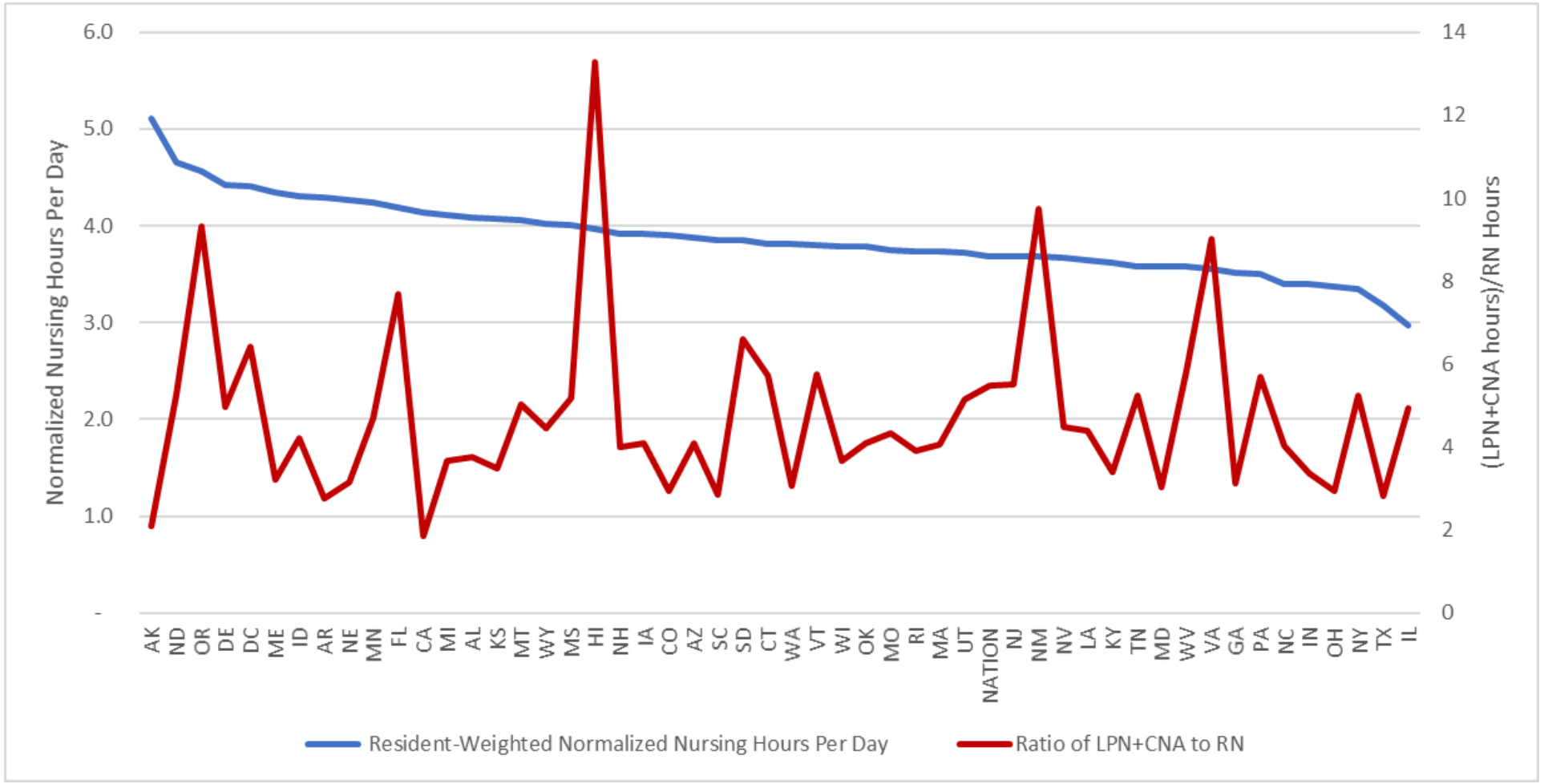

States with lower overall nurse staffing *tend* to have fewer RNs

Nevertheless, Illinois is *above* the national average for RN hours per resident day

Staffing Levels in Illinois SNFs

- **Illinois is at the bottom of national rankings on overall nursing hours**
  - For RNs+LPNs+CNAs, US averages 3.78 hours per resident per day and IL averages 3.36
  - For RNs only, Illinois (.8 hrs) is slightly above the national average (.7 hrs) in normalized hours per resident day
  - Source: *currently-posted* PBJ data (case mix adjusted; facility-weighted)

- **Total staffing falls slightly below the STRIVE study target**
  - ~270,000 hours of *direct* staffing in Illinois SNFs each day
  - Statewide staffing is about 3% below a statewide STRIVE target for total hours
  - Sources: 4Q2019 MDS scores (n=720), Q42019 PBJs (n=625), and applying RUGS-IV 48 STRIVE targets (as in Round 1 CARES/CURE funding)

- **Staffing varies widely across Illinois SNFs**
  - SNFs that are below the STRIVE target miss the target by a combined 12%
  - SNFs that are above the STRIVE target exceed the target by a combined 9%
  - In total*, each group* departs from the STRIVE target by 10s of thousands of hours per day
  - Source: 4Q 2019 PBJs (n=625)

Staffing Composition in Cost Reports and the PBJ

- **Employee v. contract staffing in Cost Reports**
  - Attempted to use 2018 and 2019 CR data
  - SNF Staffing (RN, LPN, and CNAs) appears to be +/- ~2% “consultant”
  - Therapists only show .1% “consultant”
- **Employee v. Contract staffing in the PBJ**
  - Contract v. employee: no real difference with CR measure of nursing “consultants”
  - PBJ counts of “contracted” therapy are much higher than CR count of “consultants”
    - 78% of all therapy time (.36 hours per resident day on average) was contracted
    - There is a -.13 correlation with County NF Census and % therapy time contracted
      - Cook County’s consultant therapist percentage is 69% DuPage’s 70%, Lake 64%
      - Kane is at 100% and Will 91%

Potential Payments for Retention

"The Department shall allocate an amount for staff retention. To receive the quality incentive payment for this measure, the facility's staff retention rate shall meet or exceed the threshold established and published by the Department based upon statewide averages and must be at least 80 percent.

1) Retention relates to the extent to which an employer retains its employees and may be measured as the proportion of employees with a specified length of service expressed as a percentage of overall workforce numbers.
2) The staff retentions shall reflect the percentage of individuals employed by the facility on the last day of the previous calculation period who are still employed by the facility on the last day of the following calculation period.
3) Staff retention shall be calculated on a semiannual basis.
    A. The June 30 calculation will be based on the percentage of full-time (defined as 30 or more hours per week) direct care staff employed by the nursing facility on January 1 and still employed by the nursing facility on June 30. The deadline for reporting this information shall be July 31. Direct care staff is defined as certified nursing assistants.
    B. The December 31 calculation shall be based on the percentage of full-time direct care staff employed by the nursing facility on July 1 and still employed by the nursing facility on December 31. The deadline for reporting this information shall be January 31.
4) The staff retention rate is calculated using full-time direct care staff employed in a facility.
5) Documentation in the employee's record shall support the retention rate submitted.
6) Facilities shall submit the required information to the Department in a format designated by the Department."

Source: JCAR 89(I)(d)147.345

Potential Payments for Continuity

"The Department shall allocate an amount for consistent assignments. To receive the quality incentive payment for this measure, the facility shall meet the threshold established and published by the Department based upon statewide averages.

1) Consistent assignments shall be calculated on a semiannual basis. The deadline for reporting this information shall be July 31 and January 31, respectively.
2) The facility shall have a written policy that requires consistent assignment of certified nursing assistants and it shall specify a goal of limiting the number of certified nursing assistants that provide care to a resident to no more than 8 certified nursing assistants per resident during a 30-day period.
3) Documentation shall support that no less than 85 percent of Long Term Care residents received their care from no more than 8 different certified nursing assistants during a 30-day period.
4) There shall be evidence the policy has been communicated, and understood, to the staff, residents and family of residents.
5) Facilities shall submit the required information to the Department in a format designated by the Department."

Source: JCAR 89(I)(d)147.345

Potential Policy Objectives, Considerations and Remaining Questions

Potential Objective	Considerations	Key Questions
***Reduce* understaffing**	• Poor management reduces job satisfaction, increases turnover and is difficult to fully compensate • Infection control would improve at or above minimum staffing levels	• Are low-staff NHs generally low-performing? • How to improve low-performing facilities? • What other facility characteristics affect job satisfaction (e.g., location, age, size, case mix)?
Increase staffing (broadly)	• Increasing overall staffing levels would also reduce resident assignment ratios	• How might the nursing market respond to increased demand?
Increase staffing continuity	• Continuity can be measured with turnover, retention, tenure, patient assignment durations (or consistency), and resident-staff-assignment ratios	• How important is CNA turnover and can it be reduced? • Would assignment ratios inevitably improve with increased overall staffing ratios? • How tightly are staffing assignments managed?

Evaluating the Potential to Improve Patient Care through Staffing Regulation and Payment

Potential Objective	Theoretical Roles for Regulation	Theoretical Roles for Payment
***Reduce* understaffing**	• Define regulatory minimum(s) • Penalize under-staffing	• Link payment to staffing minimums • Incentives • Link payment to employment conditions that contribute to under-staffing
Increase staffing (broadly)	• Define scopes of practice or health professions to support career pathways • Incorporate staffing levels into facility licensure reviews	• Link payment to staffing levels • Reward increases and/or higher levels
Increase staffing continuity	• Establish regulatory targets for assignment and retention • Require the adoption of staffing policies, management practices, and reporting • Penalize low continuity or retention	• Link payment to the composition, tenure and/or resident assignments of facility staff • Tie payment or incentive programs to staffing policies, management practices, work conditions, reporting, etc.

Issues and Considerations for Staffing

The full list of issues is to be revisited in future phases

- **What staffing policy objectives might be reflected in a Medicaid payment formula?**
  - **Pushing the statewide average up?**
  - **Raising the lowest facility averages up to a minimum?**
  - **Tightening resident-to-staffing assignments?**
  - **Increasing staff continuity and within-facility tenure?**
- **Should changes to the current regulatory standard incorporate additional types of direct care staff?**
- **Should the regulatory and payment standards be aligned?**
- **Should staffing be separately reimbursed?**
- **How detailed should staffing be tracked and reimbursed/funded? How precisely should skilled v. unskilled staffing be regulated and compensated? Is there a current mismatch between measured case mix and necessary skill mix?**
- **What are the implications for data collection?**
  - **Operational/procedural and cash flow implications?**
  - **Relationship between case mix profiles used in payment and regulation of staffing ratios?**
- **Would PDPM need to be (re-)calibrated to match Medicaid's case mix, i.e., are there case-types that are missing or mis-calibrated? What was the patient base for the studies and models now underlying Medicare PDPM CMIs?**
- **How might the VPD duration/stage adjustment be addressed in a state payment methodology?**
- **Should the state mimic Medicare by building rates from individuals up into an aggregate for facilities?**
  - **How "prospective" would state payment be v. also reconciling to observed case mix over time?**

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STAR Rating System: Overall

Health Inspection Stars

+

1 Star if:
- Staffing is 4 or 5 Stars; AND
- Staffing Stars > Inspection Stars

0 Stars if:
- Staffing is 2 or 3 Stars; OR
- Staffing Stars <= Inspection Stars

-1 Star if:
- Staffing is 1 Star

+

1 Star if:
- Quality is 5 Stars; AND
- A Staffing Star wasn't already added to a 1-Star Inspection Rating

0 Stars if:
- Quality is 2 - 4 Stars;

— One Star if:
- Quality is 1 Star

=

Overall Star Rating (1-5)

STAR Rating System for Staffing
(using normalized or CM-adjusted hours/resident day)

Staffing and Rating (updated April 2019)

RN rating and hours		Total nurse staffing rating and hours (RN, LPN and nurse aide)				
		1	2	3	4	5
		< 3.108	3.108–3.579	3.580 - 4.037	4.038–4.407	≥4.408
1	< 0.317	★	★	★★	★★	★★★
2	0.317 - 0.507	★★	★★	★★	★★★	★★★
3	0.508–0.730	★★	★★★	★★★	★★★	★★★★
4	0.731–1.048	★★★	★★★	★★★★	★★★★	★★★★
5	≥1.049	★★★	★★★★	★★★★	★★★★★	★★★★★

Staffing thresholds are absolute and based on staffing-quality relationship. For inspection-based Star ratings the target distribution is: Top 10 percentile Five Star; 10-33.33rd Four Stars; 33.34-56.66th Three Stars; 56.67-90th Two Stars; Bottom 10 percentile 1 Star)

STAR Rating System for Quality

Point Ranges for the QM Ratings (as of October 2019)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	155–469	144-473	299–943
★★	470–564	474–567	944–1,132
★★★	565–644	568–653	1,133–1,298
★★★★	645–734	654–739	1,299–1,474
★★★★★	735–1,150	740 – 1,150	1,475–2,300

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1,150/800 to the unadjusted scores)

Scoring inspections for the STAR Rating System

Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	**Pattern**	**Widespread**
Immediate jeopardy to resident health or safety	**J** 50 points* (75 points)	**K** 100 points* (125 points)	**L** 150 points* (175 points)
Actual harm that is not immediate jeopardy	**G** 20 points	**H** 35 points (40 points)	**I** 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	**D** 4 points	**E** 8 points	**F** 16 points (20 points)
No actual harm with potential for minimal harm	**A** 0 point	**B** 0 points	**C** 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care.

STAR Rating System for Inspections

Inspection-based Star ratings are based on weighted point comparisons within states.

The target distribution is:

- Five Stars Top 10 percentile
- Four Stars 10^{th}-33.33^{rd} percentile
- Three Stars 33.34^{th}-56.66^{th} percentile
- Two Stars 56.67^{th}-90^{th} percentile
- One Star Bottom 10 percentile

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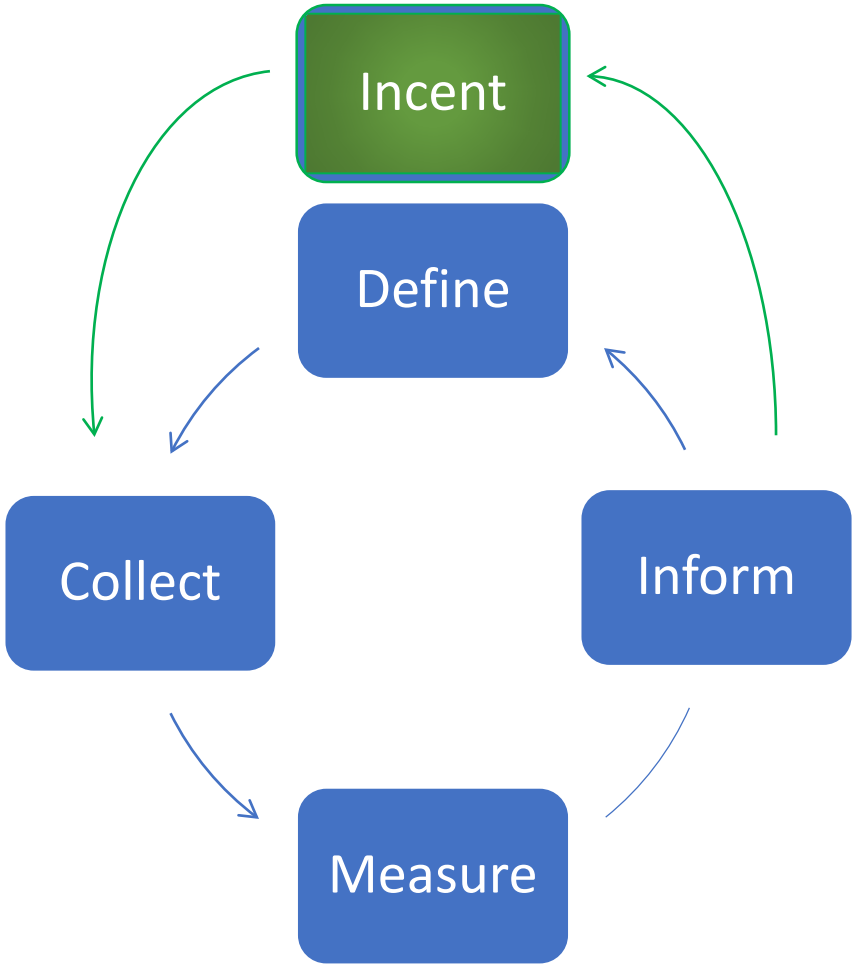
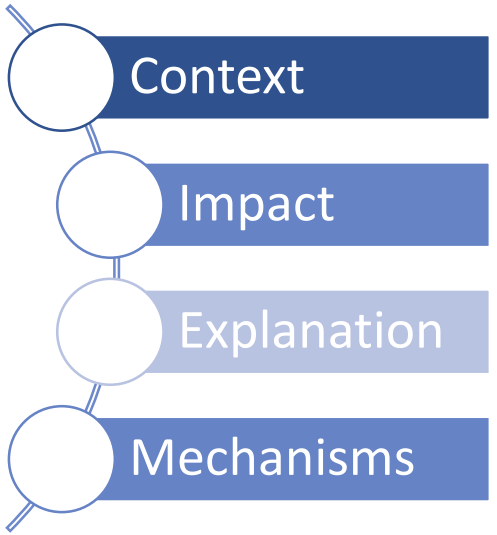
Developing and Using Outcomes

Implications for new metrics:

- We have **less information** about them, including validation of their impact, an explanation of that impact, and the mechanisms for moving the needle
- NFs also know less, and face **risk** when spending money to move the needle
- In addition, NFs face the economic **incentive to wait** for others to solve the puzzle
- Risk and this '**tragedy of the commons**' predictably lead to collective under-investment
- So what approach should the state take with new metrics?





Characteristics of Outcome Metrics that Matter

Characteristics of interest to NFs

- _____?
- _____?

Characteristics that matter to the state

- _____?
- _____?

Evaluating an Outcome Measure

Defining Outcome Types

Outcome Maturity	Expected age of metric (illustrative)	Metric definition and intepretation	What is known about the potential for success	Historic pattern of performance
New	0-2 years	Meaningful concerns about validity and/or reliability	Little or nothing	No established baseline
Mixed	2-5 years	Only modest concerns about validity and reliability	A fair amount	Established baseline. Variable/mixed performance across NFs implies under-performance.
Mature	3+ years	Validity and reliability well-established	Enough to set an aspirational threshold	Multiple NFs have achieved success, which is well-understood, informing a target performance

Evaluating an Outcome Measure

Examples of Policy Objectives

Outcome Maturity	Example policy goals in incentive design
New	Coordinate/motivate broad initial investments by NFs
	Learn from investments and varying NF initiatives
Mixed	Improve overall (and top) performance
	Motivate rapid improvement & investment by low-performers
Mature	Maintain target performance; prevent degradation across many outcomes
	Bring all performance up at margin?
	Eliminate remaining under-performance

Evaluating an Outcome Measure

Potential Role of Competition

Outcome Maturity	Reward to NF collaboration	Potential for competition	Potential for competition to incent	How might NFs compete?
New	Negative	Performance ROI is unknown, and creativity encouraged, compounding NFs' investment risk	??	NFs receive base amount and broadly compete for a smaller pot of incentive/innovation money
Mixed	Neutral?	Medium: performance ROI is known for under-performers, but they cannot win	??	??
Mature	Conditional/Partial	Low: state does not wish to induce investment above performance threshold	??	??

Evaluating an Outcome Measure

Implications for Incentive Design

Outcome Maturity	Benchmark for success	Potential metric	Example of financial incentive
New	Other SNFs	Percentile	Positive financial incentive, with baseline/floor to support minimum investment
Mixed	Self	Total improvement	Pay-for-point changes, positive or negative
Mature	Threshold	Performance poverty (weighted under-performance)	Negative financial penalty

Available Levers to Improve Outcomes

- Licensing and regulation
  - CON
  - Operation
- Payment and financial incentives
  - Capital costs
  - Administration and support
  - Direct care
  - Profit
  - Quality (if separate)
- Placement and participation
  - Resident placement
  - Medicaid network
- Public reporting
  - Resident choice

Characteristics of Levers that Matter

Characteristics of interest to NFs

- Cash flow, i.e., how long after an NF investment would improvement $$ come?
- Uncertainty of payoff v. investment in improving the metric
- _____?
- _____?

Characteristics that matter to the state

- Focus, i.e., will NF response match state policy priorities?
- Does the scale of reward match the value of the outcome?
- _____?
- _____?

Characteristics of *Potentia*/NF Outcome Levers

Assessment for Comment and Feedback

NF Lever*	Description	Is the $ impact potentially +? potentially -?	Could incentive be continuously scaled?	Is incentive shared (competitive)?	Target for improvement?	Can lever target individual outcomes?	Lag	Duration
Payment Incentive	Dollar or percentage adjustments to (part of) the per diem	− or +	Yes	Potentially Yes, but to a scaleable degree	All and/or low performing NFs	Yes	At least 6 months?	Flexible, e.g., minimum 3-6 months
MCO LTC placement	Influence or incent community v. NF 'A' v. NF 'B' placement	− or +	Yes	Potentially Yes	All and/or low performing NFs	Yes	At least 3-6 months?	Flexible, e.g., as little as 1-2 months?
CON	Requirements for new investment	− or +	Yes	Potentially Yes	All and/or low performing NFs	Yes	??	Flexible?
Regulatory minimums	$ Penalties	−	Yes	No	Low performing NFs	Yes	??	Flexible
Medicaid participation	Transition of all current Medicaid residents	−	No	No	Very low performing NFs	Yes for limited number of outcomes	??	Medium to long-term
Licensure	Transition of all current residents	−	No	No	Very low performing NFs	Yes for limited number of outcomes	??	Medium to long-term

*Not a characterization of current Illinois policy. Some options would require policy changes to be deployed.

Matching Levers to Outcomes

Key Questions

NF Lever*	Description	New Outcomes	Mixed Outcomes	Mature Outcomes
Payment Incentive	Dollar or percentage adjustments to (part of) the per diem	Are payment incentives flexible enough to support NF experimentation?		What is the remaining potential for improvement?
MCO LTC placement	Influence or incent community v. NF 'A' v. NF 'B' placement		What is the MCOs' role in managing NF/LTC outcomes?	
CON	Requirements for new investment		Which types of outcomes might fit this lever?	
Regulatory minimums	$ Penalties		Which outcomes work best here? Would regulations compliment payment incentives?	
Medicaid participation	Transition of all current Medicaid residents		Would any such outcome rise to this level of importance?	Which outcome(s) might rise to this level of importance?
Licensure	Transition of all current residents		Would any such outcome rise to this level of importance?	Which outcome(s) might rise to this level of importance?

*Not a characterization of current Illinois policy. Some options would require policy changes to be deployed.

Questions & Next Steps

- Questions and brief comment on today's content
- Next Meeting: Quality Week 2
  - Individual quality metrics
  - Performance in Illinois and other states
  - NF quality improvement efforts in other states
- Request for content