Today’s Agenda

• Overview and Recap of Week 2
  • New building block
  • Non-Nursing PDPM components
  • VPD adjustment
  • STRIVE’s “other” staffing category

• Questions and brief comment

• Staffing Week 3
  • Level and composition of staffing in Illinois SNFs
  • Defining continuity and assignment

• Questions and brief comment on today’s content

• Next Steps and Request for content
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.
Original Objectives and Principles

- 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
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 (**NEW**)*
• 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.
Relevant to Today’s Discussion on Staffing:

- 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
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- Build in flexibility to evolve as the industry evolves and establish ongoing channels of communication for new, proposed, or upcoming changes
Today’s Focus

• 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?
Composition of PDPM v. RUGS

**Key Differences**

**Timeframe**
- Section G has retrospective 7-day window
- Section GG has a 3-day window at the beginning of a PPS stay

**Content**
- Section G assesses ADLs (10), Bathing, Balance, Range of Motion, Device use, and Rehab Potential
- Section GG assesses Prior Device Use, Everyday Activities (4), Self Care (7), and Mobility (10)

**Classification algorithm**
- RUGS incorporates 4 ADLs from Section G
  - Bed Mobility, Transfer, Eating, Toilet Use (both columns)
- PDPM incorporates these from Section GG
  - 11 ADLs from Self-Care and Mobility sections, including Eating, Toilet Hygiene, Sit to Lying, Lying to Sitting, Sit to Stand, Chair/Bed Transfer, Toilet Transfer

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CMS’ original plan was to eliminate Section G and add Section GG effective 10/1/2020, but allowed states to retain Section G, which Illinois did.

Recap and Overview: Staffing Week 1
### Staffing Effort (hours/day)

<table>
<thead>
<tr>
<th>Resident Classifications</th>
<th>RN</th>
<th>LPN</th>
<th>CNA</th>
<th>Therapy</th>
<th>Other...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate</td>
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<tr>
<td>Skilled</td>
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</tbody>
</table>

**Contribution to case mix-adjusted direct care staffing minimum for facility:**

- **2.5 hours per resident day**
- **3.8 hours per resident day**
State payment for SNF staffing (per diem for each resident)

Deriving a CMI weight for each RUG

Staffing Skill (implied relative wage ratio)  Staffing Effort (implied hours/day)

<table>
<thead>
<tr>
<th>Resident Classifications (RUGS IV)</th>
<th>RN</th>
<th>LPN</th>
<th>CPA</th>
<th>Other...</th>
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<tbody>
<tr>
<td>AA1</td>
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<td>BA1</td>
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<td>BB2</td>
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<tr>
<td>CA1</td>
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<td>CA2</td>
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</table>

Patient Classifications (RUGS IV)

<table>
<thead>
<tr>
<th>RN</th>
<th>LPN</th>
<th>CPA</th>
<th>Other...</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA1</td>
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<tr>
<td>BA1</td>
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<td></td>
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<td>CB2</td>
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<tr>
<td>...</td>
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<td></td>
</tr>
</tbody>
</table>

How to read this diagram...

Each solid-line box represents a unique patient-type + staff-type combination that contributes to rate development or compliance.

State Base Wage for Staffing (implied $/hour)

Important Note: Separation of skill and effort and associated dotted line detail reflects only the initial, historical calculation of CMIs by Medicare.
STRIVE Time Study
Background for Potential Application to Payment or Regulation

STRIVE Nursing Staff Time Package
11/28/2011 V1.00

Table 1.
Staff Categories, Roles and Wage Weights

<table>
<thead>
<tr>
<th>Staff Category</th>
<th>Staff Role Label (in CSV Files)</th>
<th>Staff Role Description</th>
<th>Wage Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>RN</td>
<td>Registered Nurse</td>
<td>2.58</td>
</tr>
<tr>
<td></td>
<td>Resp. Ther.</td>
<td>Respiratory Therapist</td>
<td>2.14</td>
</tr>
<tr>
<td>LPN</td>
<td>LPN</td>
<td>Licensed Practical Nurse or Licensed Vocational Nurse</td>
<td>1.65</td>
</tr>
<tr>
<td>Aide</td>
<td>CNA, GNA, RCT</td>
<td>Certified Nursing Assistant or Geriatric Nurse Assistant or Resident Care Technician</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Cert. Med. Aide</td>
<td>Certified Medication Aide</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Restor. Aide</td>
<td>Restorative Aide</td>
<td>1.20</td>
</tr>
<tr>
<td></td>
<td>Bath Aide</td>
<td>Bath Aide</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Feeding Aide</td>
<td>Feeding Aide</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Psych Aide</td>
<td>Psychiatric Aide</td>
<td>1.08</td>
</tr>
<tr>
<td></td>
<td>Non Cert. Care Tech</td>
<td>Non Certified Care Technician</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Clin. Assoc.</td>
<td>Clinical Associate</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Transportation</td>
<td>Transportation Aide</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Resp. Ther. Asst.</td>
<td>Respiratory Therapist Assistant</td>
<td>1.76</td>
</tr>
</tbody>
</table>

Source: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy)
## Therapy in RUGS v. PDPM

### Assessment of need for therapy

**RUGS-based payment**

- Uses initial 5-day and quarterly MDS
- Based on the number of days & minutes coded and ADL function there are two ways to meet RUGs Rehab Category:
  - \( \geq 5 \text{ days AND } \geq 150 \text{ minutes in any therapy; or} \)
  - \( 3 \text{ days AND } \geq 45 \text{ minutes in any therapy AND } \geq 2 \text{ restorative interventions} \)

**PDPM-based payment**

- Uses initial 5-day MDS
  1. Determine the resident’s primary diagnosis clinical category using ICD-10 codes AND whether to use default diagnosis instead. Determine whether the resident received a major joint replacement, spinal surgery, orthopedic surgery, or significant non-orthopedic surgical during prior inpatient stay (Several options)
  2. Determine the resident’s PT Clinical category (11 options)
  3. Calculate the function score using items in GG
  4. Determine the resident’s PT group using case mix table

### Impact on payment

**RUGS**

- Raises facility’s CMI with 2Q lag
- Facility’s provision of therapy factors directly into future payment

**PDPM**

- Need for therapy affects the CMI-based prospective payment
- Facility’s provision of care does not factor directly into payment
New Medicare PDPM Staffing Payment Methodology (per diem for each resident)

CMI-adjusted rate formula for each Patient for each component ($ per day)

Staffing Skill ($wages)  \[ \times \]  Staffing Effort (hours/day)

PT  OT  SLP  NTA  Nursing

PT CMI  OT CMI  SLP CMI  NTA CMI  Nursing CMI

VPD Adjustment (stage w/in limited 0-100 day stay)

How to read this diagram...

Each solid-line box represents a unique patient-type + staff-type combination that contributes to rate development or compliance.
## Data Sources for Each PDPM Case Mix Index

<table>
<thead>
<tr>
<th>Clinical Category (ICD-10 mapped to 4 PT&amp;OT Categories)</th>
<th>Functional Score (sum of ten GG item scores)</th>
<th>Acute Neurologic Condition</th>
<th>SLP-Related Comorbidity or Cognitive Impairment</th>
<th>Mechanically-altered Diet</th>
<th>Swallowing Disorder</th>
<th>RUGS-IV Category</th>
<th>NTA Comorbidity Score</th>
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</thead>
<tbody>
<tr>
<td>PT CMI</td>
<td>X</td>
<td>X</td>
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<tr>
<td>OT CMI</td>
<td>X</td>
<td>X</td>
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<tr>
<td>SLP CMI</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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<tr>
<td>NTA CMI</td>
<td></td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Nursing CMI</td>
<td>X</td>
<td></td>
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<td>X</td>
</tr>
</tbody>
</table>

**We plan to revisit CMI later in the process**
Hypothetical STRIVE-Based Staffing Hours by Payer
MDS 4Q 2019; All Direct Care Staff Time

Recap and Overview: ‘Other’ Strive Staffing Categories

Notes:
• Staff time by payer and resident is not tracked and recorded. These allocations are a hypothetical characterization for illustrative purposes only.
• **NEW** Other Staff include Cert. Med. Aide, Restor. Aide, Bath Aide, Feeding Aide, Psych Aide, Non Cert. Care Tech, Clin. Assoc., & Transportation Resp. Ther. Asst.
Staffing Levels in Illinois SNFs

- **Illinois is very close to the national staffing average**
  - For RNs only, both the US and IL average .38 hours per resident per day
  - For RNs+LPNs+CNAs, US averages 3.21 hours per resident per day and IL averages 3.29
  - Source: currently-posted PBJ data (case mix adjusted)

- **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)

**NOTE:** This slide contains incorrect analysis and interpretation. Please see October 22, 2020 supplemental presentation for corrected analysis and interpretations.
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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%
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)
State Rankings for Nurse Staffing Ratios
(All case-mix adjusted; source Medicare COMPARE 10.12.2020)

**Key staffing indicators tend to move together…**

- States with lower overall staffing ratios also tend to have:
  - fewer RNs
  - fewer RNs per non-RN

Illinois is very close to the national average in both

NOTE: This slide contains incorrect analysis and interpretation. Please see October 22, 2020 supplemental presentation for corrected analysis and interpretations.
Level and Composition of Staffing in Illinois SNFs

Distribution of State 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.

Raising all below-target SNFs would raise Illinois’ average to #1 nationally (by far)
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• Next Steps and Request for content
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
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

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

Defining Continuity and Assignment

Potential Objective:

What Other Potential Objectives are There?

- Reduce understaffing
- Increase staffing (broadly)
- Increase staffing continuity

Considerations:

- Poor management reduces job satisfaction, increases turnover and is difficult to fully compensate
- Infection control would improve at or above minimum staffing levels

Key Questions:

- 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)?

- How might the nursing market respond to increased demand?
- 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

### What Other Potential Roles are there?

<table>
<thead>
<tr>
<th>Potential Objective</th>
<th>Theoretical Roles for Regulation</th>
<th>Theoretical Roles for Payment</th>
</tr>
</thead>
</table>
| **Reduce understaffing** | • Define regulatory minimum(s)  
• Penalize under-staffing | • Link payment to staffing minimums  
• Penalties  
• 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. |
At what stage is Illinois for:
• Reducing understaffing?
• Increasing overall staffing?
• Increasing continuity?

Developing and Using Staffing Outcomes
Questions & Next Steps

• Questions and brief comment on today’s content
• Next Meeting: Quality Week 1
• Request for content