

Questions as submitted by Nancy Moraski on April 8th – Answers by HFS in red, discussed on April 15, 2021

Page 20- Quality Strategy Objectives: Keep them more closely connected with families and communities:

1. *Nursing Home* bed tax money will be actively diverted from Medicaid nursing home rates to pay for community based programs that historically are not at all available in rural locations and provide a service that is sub-acute to Long Term Care which is often 24 hour nursing care. What assurances are there for *rural* seniors that they can access long term care in order to *remain in their community*? We have Supportive Living and CCP resources in every county in the state, including many SLCs in rural areas. If funding is NOT invested in these sub-acute community settings, then the options potentially lessen.
2. To stimulate rebalancing, in a more equitable and cooperative fashion to LTC, has the Department considered utilizing a smaller portion of LTC's money for community service and the remainder as incentives for discharge to community percentages, in a quality program? That's an interesting proposition. Instead of SB 1664 (which prohibits incentive in managed care), let's talk about how we can pass some of those incentives through to cooperative facilities and also talk about what this suggestion might look like otherwise, so we can consider if we can lower that number.

Page 20- Quality Strategy Objectives: Proactively uses analytics and data to drive decisions:

1. Please provide "data analytics" to support HSA wage adjusters. There is none. We were attempting to not cut the base rate and instead build on it, with the exception of updating the CMI.
2. There has been an enormous amount of data presented over the course of many months. The data that seems to be missing from the Department is the correlation of Nursing Staffing Rates to Medicaid Nursing Rates among the states (see pg 31-35 of HCCI Report Final Draft- 2/9/21 email). Without adequate funding of care, adequate staffing is difficult to achieve. Would the Department consider a shift of a portion of the community based funds- 9/18 million of the 49/100 million of the assessment fee generated to the Nursing Base Rate to accommodate a small portion of the cost of care deficit experienced by the LTC facilities in Illinois? Thank you for the suggestion.
3. It appears from months of discussions that all involved support the premise that nursing staffing has implications toward quality care. But, is it necessary to include 5 different measures of staffing guised as quality into this Medicaid rate?
 - a. Wage Adjusters

- b. Staffing Add-on
 - c. Nursing Care Incentive
 - d. Staffing Continuity
 - e. Staffing Turnover
 - f. For ease of calculation and consistency of data driving decisions, it is possible to eliminate the archaic wage adjusters, *absorb the Staffing Add-On into the Nursing Base Rate* (and eliminate all cumbersome reporting and incongruence with STRIVE which the rest of model is based upon) and work with the remaining 3 Staffing Quality Initiatives? **a. and b. are not in our proposal. c. does go to base rate through the nursing care incentive, but only if facilities meet staffing levels. d. and e. are already in regulations and we are proposing to fund them.**
4. Does the Department concede that some turnover in staffing is desirable? Minor changes in a small staffing census make for large percentage changes eliminating the eligibility for percentage based incentives.
- a. Most nursing schools require CNA certification and experience before moving on; promotion and succession training is desirable. It would be a disservice to the industry to eliminate the use of these transient students because they will be counted as quick turnover in the facility workforce. **Thank you for the suggestion. We understand that it asks for consideration in the design of policies that encourage hiring of trainees v. those that encourage tenure.**
 - b. Each facility needs to be confident and empowered to eliminate staff that is not conducive to a healthy and happy resident environment. For small facilities a few people equals a small percentage! Does the department really want to force facilities to weigh letting go of bad or mediocre staff to meet turnover incentives? This is especially impactful in smaller homes. **This and other quality metrics will need to be reviewed for any required adjustments prior to implementation. We look forward to working with providers and other stakeholders to ensure fairness and achieve the aims outlined in our proposal.**
5. Currently staffing agencies have a strong hold over potential hires in that they are prohibited from working in any LTC Facility they have been assigned to for one year. Any agency worker looking to leave agency has their earning power stripped from them and any LTC facility that uses agency is crippled by their own need. If the Department is committed to assisting with staffing, what can be done to mitigate these issues? **These sound like potentially unfair labor practices. Are you suggesting that this issue be addressed in law?**

1. Is the Department considering with this rate revision, eliminating the occupancy rate penalty to incentivize facilities to reduce to single or double room occupancy from multi-room occupancy, allowing facilities to financially consider this option? **Thank you for the suggestion.**
2. If the Department's focus is equity, should the wage adjusters that cause regional disparity be removed from the proposal? **Thank you for the suggestion.**
3. Medicare uses a Non-Therapy Ancillary Base Rate in lieu of a Capital and Support Rate. This is geographically set to accommodate for mortgage rates, etc. The Department has demonstrated it does have cost reports for most all facilities, has there been considerations for a standard NTA base rate per region to replace the Capital and Support Rate that can be updated every 2 years for inflation? **We wanted to reserve this conversation for a later year but are willing to have it if folks want to.**
4. As an individual who follows the same survey team from one facility to another back to back, the current survey process is not always impartial. Regarding "equity", as the Department intends to tie reimbursement incentives to Survey Stars, what is the plan to move Illinois toward the QIS survey system? **We will discuss this with our sister agency.**

Page 20- Quality Strategy Objectives: Pays for value and outcomes.

1. Several slides suggest Quality Metrics based on the 5 Star System. The 5 Star System has been known to be "frozen" a number of times for a number of consecutive months. How will a facility's Medicaid rate be affected by a freeze in the 5 Star rating system? Will a facility be able to appeal a rate frozen at a lesser reimbursement if able to prove improvement in metrics? **We could accelerate substitution or temporarily replace metrics frozen more than 6 months.**
2. While all involved on the calls seem to understand the correlation between staffing and care quality, perhaps not all understand the challenge of workforce issues. Facilities truly do want to staff for acuity. Currently under the 5 Star Staffing Reporting, if a facility is missing 4 out of 92 days with no RN, their staffing star will be suppressed. Does this mean that the facility will be ineligible for no incentive staffing payments for the entire quarter based on just those 4 days? **No. We are proposing to use STRIVE standards directly, not the Star staffing measure.**
3. Inspection Star Rating- Will each facility be considered for incentive payment based on their actual inspection *score* to determine their star rating for incentive or by their actual "Star Rating" within the state? As you know, only the top 10% of the lowest scores get a 5 star rating, and despite their score, 20% of the highest scores MUST be in the 1 Star category. If incentivized by their Star Rating instead of their score, some facilities may not be compensated fairly. **Good suggestion. Worth discussing how to make Inspection absolute rather than relative.**

4. What will be the process for considering incentives for facilities that did not generate a long stay QM score for the quarter? Of first importance is settling on an initial set of quality metrics. Measurement and inclusion protocols for each would be addressed in operational details that follow. We have discussed looking back at least one more quarter if data is missing and would likely introduce some sort of penalty for continued data suppression by CMS due to facility data issues. We are open to discussing design of the quality improvement program. This includes continued discussion on selection of metrics in the program's initial time periods.