

**NURSING HOME MEDICAID STUDY
LEGISLATIVE REPORT**

Agency of Human Services
Department of Aging and Disabilities

January 15, 1998

I. Introduction

Section 270d of the 1998 Appropriations Act directs the Secretary of the Agency of Human Services to conduct a "Nursing Home Medicaid Study" analyzing the reimbursement methodology for nursing homes and develop recommendations for alternative approaches to nursing home reimbursement "which promote quality of care while at the same time allowing for reasonable flexibility and equity with other service providers in the state budgeting process."

In concurrence with this legislative mandate, the Secretary commissioned a comprehensive study of the current long-term care delivery system, focusing on the distribution of Medicaid funds to long-term care service providers, both institutional and community-based. The expressed goals of the study were to develop recommendations for redesigning the current reimbursement methodologies in a manner which (1) assures that Vermont nursing homes receive sufficient funding to provide high quality care to the elderly and disabled patients residing in those facilities, and (2) achieves the budgetary targets established by Act 160 for redirecting almost \$20 million in Medicaid funds to home and community-based providers by FY 2000 which otherwise would have been spent in nursing homes. In compliance with Act 160, a crucial objective of this exercise was to redress the historic imbalance in funding between institutional and community-based providers. The timing of the study also coincided with the need to update the existing case mix reimbursement rules, scheduled to sunset on June 30, 1998.

II. The Secretary shall study the impact upon the Medicaid and general fund budgets of the current rebasing methodology and guaranteed annual inflation adjustments for nursing homes

Analysis of Medicaid spending over the last 10 years confirms that the outlays for Vermont's nursing homes increased dramatically in the years between 1989 and 1995 – from \$38,489,176 to \$72,402,043. Annual inflation adjustments, calculated by the Division of Rate Setting utilizing regional and national health care sector inflationary trends, played a role in driving this growth, but inflation was probably not the dominant factor. More important influences can be traced to rebasing, introduction of the case mix reimbursement system in 1990, and a significant increase in the supply of nursing homes beds between 1989 and 1995.

Rebasing is a component of the reimbursement process which periodically assesses and updates the costs of running a nursing home and reflects those increased costs in computation of the nursing home's Medicaid rate.

During consideration of the 1997 Appropriations Bill, testimony was offered suggesting that rebasing of nursing home costs and the annual inflation adjustment should be eliminated, since community-based providers do not enjoy the same sort of financial protections. The Agency of Human Services carefully considered the feasibility of repealing rebasing and inflation adjustment, but concluded that such a statutory change would be ill-advised under the current circumstances.

It is undeniable that funding for nursing home care has historically consumed most of Vermont's Medicaid budget for long-term care (see Section IV below) and that community-based providers have experienced nearly a decade of level-funding while nursing home outlays increased steadily. Nevertheless, the Agency believes that the answer to redressing this imbalance is to adhere to the approach outlined in Act 160, which gradually diverts almost \$20 million in funding from nursing homes to community-based providers over a four-year period. The Agency of Human Services has demonstrated its commitment to the Act 160 budget targets by incorporating them into the spending plans developed for FY 97, FY 98, and FY 99. This shift of Medicaid dollars has already made possible sizable increases in the Medicaid waiver program and adult day services. Continued implementation of Act 160, in FY 2000 and beyond, will plot a course of steady growth in the community-based delivery system, while downsizing Vermont's nursing home industry.

The key to containing nursing home costs is not to erode the industry's reimbursement rates, but rather to reduce its size. Under the current circumstances, the Agency believes that repeal of rebasing and the annual inflation adjustment may diminish a nursing home's capacity to hire and/or retain qualified staff or maintain its physical plant. As discussed in the next section of this report, the costs of running a nursing home -- including staff, medications, and therapeutic services -- are affected by inflationary pressures. Freezing the reimbursement level without reducing the size of the patient population would eventually pose a serious threat to the quality of patient care, as inflation of the facility's costs forced it to reduce spending on these critical needs.

The approach described in Act 160 is a more palatable method of redressing the funding imbalance between institutional and community-based care. By gradually reducing the supply of Medicaid-funded nursing home beds in Vermont, we can ensure that funding available for nursing home care keeps pace with economic reality. This is the course the Agency of Human Services has determined to pursue. Through a mixture of innovative conversions of nursing home beds to other uses and proposed changes in the reimbursement system, the Agency will steadily reduce the number of nursing home bed days purchased by the Vermont Medicaid program in order to achieve the Act 160 spending objectives. This will do far more to promote the growth of the home- and community-based system than tampering with the nursing home industry's rates.

III. The Secretary shall study mechanisms for maximizing staff salaries

During the 1996 legislative session, legislators were disturbed to learn that some nursing home owners were realizing sizable profits and benefiting from generous compensation arrangements, while other nursing home administrators expressed frustration at their inability to attract qualified nursing staff due to economic competition for entry-level service employees. In response to these concerns, the Senate Appropriations Committee inserted language into Section 270d of the 1997 Appropriations Act, directing the Agency to study methods for maximizing staff salaries.

When the legislation was under consideration in the Senate Appropriations Committee, some members expressed the sentiment that future inflation increases in the Medicaid nursing home budget should be entirely directed to staff compensation. The Agency considered the possibility of using the rate setting process to direct future inflation adjustments to staff salaries, but concluded that this approach suffered from several serious flaws.

First, a nursing home's budget consists of several cost categories besides nursing staff salaries. Costs of running a nursing home include debt service, building upkeep and maintenance, medications and supplies, durable medical equipment, purchase of therapeutic services (*e.g.*, speech therapy, physical therapy and psychiatric consultations), social services and activities, and transportation. Requiring a nursing home to expend the annual inflation adjustment on staff compensation would eventually erode the capacity of a nursing facility to direct appropriate resources into these other costs categories, all of which are affected by inflationary pressures. Over time, the facility's diminished spending power with respect to non-salary items would have an adverse effect on the quality of patient care.

Second, directing nursing homes to spend their inflationary increases exclusively on staff salaries fails to take into account regional variations in the labor market and differences in hiring practices among the various nursing homes. The current staffing shortage, a by-product of the healthy economy and declining unemployment, is felt most acutely by those facilities located in heavily populated regions of the state where numerous employers are competing for the same pool of entry-level service employees. Facilities in other parts of the state, especially rural regions, may not face the same competition for prospective staff or have already addressed the issue by significantly improving their salary scale for nursing staff in order to compete in their regional labor markets -- a cost which is recognized in the rebasing process. Requiring these facilities to allocate their inflationary adjustments exclusively to staff salary improvement might needlessly solve a problem which doesn't exist.

Instead, the Agency is recommending a three-pronged approach designed to provide nursing facilities with appropriate incentives to compensate nursing staff at a level, which attracts quality personnel and assures quality care.

First, the Agency plans to change the methodology for classifying patients in the case mix reimbursement process, adopting an updated classification system (known as the RUG or **R**esource **U**tization **G**roups). Based on time-motion studies of nursing home staff conducted by the federal Health Care Financing Administration, the RUG classification system determines how much nursing care a particular patient requires and assigns a score to each patient based upon his/her acuity. The more needy the patient, the higher the RUG score s/he is assigned. Higher scores mean higher reimbursement for the nursing home. The RUG classification system is the core of the case mix reimbursement system which provides financial incentives to nursing homes to admit and care for patients with greater needs. The RUG system now in use in Vermont has been altered several times over the past few years and certain aspects no longer reflect the resources required to provide appropriate care to patients. The Agency believes that the RUG should be revised to accurately reflect the real cost of caring for patients. With this change, many nursing homes would see an increase in Medicaid reimbursement, permitting them to hire additional staff to meet the needs of their patient population.

The Agency will also recommend eliminating the "efficiency incentive" that previously encouraged nursing facilities to reduce administrative costs by paying a small bonus in their per diem reimbursement rate. In the past few years, the efficiency incentive has lost its relevance, since it does nothing to ensure that facilities are delivering high quality care.

Indeed, the efficiency incentive may actually have an adverse effect on the quality of patient care, since nursing homes are rewarded by the efficiency bonus when they limit spending on activities other than direct nursing care, such as activities, laundry, dietary, and social services. And many facilities cannot take advantage of the incentive because their rates are capped by the GOL (General Operating Limit). Instead, the Agency eventually plans to redeploy these funds in the form of a "quality incentive", measuring a facility's performance against a set of critical clinical indicators (e.g., unplanned weight loss, use of involuntary restraints, and post-admission onset of decubitus ulcers) and rewarding facilities that demonstrate high quality care. The quality incentive would be available to any nursing facility demonstrating superior performance, regardless of its reimbursement rate. The Agency anticipates that introducing a "quality incentive" into Vermont's reimbursement system will encourage nursing facilities to increase the resources they devote to patient care in order to obtain good outcomes.

Finally, the Agency intends to release quality comparison reports to the public, allowing consumers to make informed decisions in choosing a nursing home. Utilizing a combination of clinical indicators similar to those described above and financial data such as staffing ratios, the Agency will publish quarterly reports of nursing home performance consumers can use to compare the quality of facilities. Sharing quality indicator data with consumers will yield a bonus dividend: as the nursing home industry recognizes that its performance is open to public scrutiny, the competitive forces of the marketplace will compel the industry to manage its resources in ways which ensure the quality of care we want for frail Vermonters. The Agency of Human Services expects that comparisons of employee turnover rates, staff ratios and clinical indicators will dramatically influence expenditure decisions at nursing homes in the future.

IV. The study shall specifically analyze the growth in the nursing home budget over the last 10 years as compared to the budgets of other long-term care and home- and community-based providers supported by the general fund

In response to this directive, the Agency prepared a detailed breakdown of outlays for long-term care over the period 1989 to 1998, comparing Vermont Medicaid expenditures for nursing home care during this period against funding levels for significant components of the community-based delivery system, e.g., attendant services, adult day care, homemaker services, home- and community-based waiver slots, and the state funding to area agencies on aging. Analysis of the numbers reveals that in fiscal year 1989, Vermont expended \$38,489,176 on nursing homes, while \$2,918,138 was appropriated for community-based programs. Thus, almost 93% of the \$41,407,314 total long-term care budget in FY 89 was received by the nursing home industry.

By 1996 (the last fiscal year before Act 160 took effect), Vermont Medicaid expenditures for nursing home care had sharply increased to \$73,911,253 – a 92% increase over the course of the seven years since 1989, growing at the rate of nearly 10% per year.

In that same year (FY 96), community-based programs received funding totaling \$9,623,419 – a 329% overall increase since 1989. In evaluating this figure, however, one must bear in mind that most of the growth in funding for community-based services during this period came in the Medicaid waiver program which was only a small pilot project in 1989. And almost all of the increased Medicaid waiver funding went to creation of additional waiver slots – reimbursement paid to providers of waiver services remained stagnant throughout this period. Other important parts of the community-based long-term care delivery system, such as attendant services, adult day care, and the area agencies on aging were essentially level-funded throughout this seven-year period, while support for homemaker services actually declined. Moreover, the

329% growth in funding seems impressive until one considers that community-based expenditures started from a very small base, so funding increases expressed as a percentage of the 1989 figure seem large, even though the cumulative dollars allocated were still modest compared to nursing home outlays. Remember that the size of the nursing home budget still dwarfed all community-based programs combined in FY 96, consuming 89% of total long-term care expenditures. So, despite the fact that spending for home- and community-based programs tripled between 1989 and 1996, nursing homes still consumed 9 of every 10 public dollars spent on long-term care in Vermont.

With the enactment of Act 160 in 1996, these spending trends began to change, with nursing home outlays remaining essentially flat, as the Agency shifted Medicaid dollars to community-based programs. From 1995 to 1998, Medicaid outlays for nursing home care increased only 2.1% overall – from \$72,402,043 in 1995 to \$73,986,217 by the end of current fiscal year 1998. At the same time, the proportion of the total long-term care budget devoted to community-based services increased to 16% -- a number which will continue to rise as Act 160 implementation redirects Medicaid funds towards these programs in FY 99 and FY 2000.

V. The Secretary shall develop recommendations, including proposed legislation, for alternative reimbursement methodologies which promote quality of care while at the same time allowing for reasonable flexibility, and equity with other service providers, in the state budgeting process

Drawing upon the recommendations submitted by the consultant hired to evaluate the long-term care reimbursement system, the Agency will initiate a formal rulemaking process within 60 days. The proposed rate setting rules will describe the revised reimbursement system intended to replace the current rules, which expire on June 30, 1998. As mentioned in Section III of this report, the new methodology will still employ a case mix system for weighting patient needs, though an improved version of the RUG will be used to calculate patient acuity scores. The Agency will also propose elimination of the so-called efficiency incentive, ultimately replacing it with a quality care incentive.

Among the other changes which the Agency is still considering:

- Calculating a nursing home's Medicaid reimbursement based on the needs of only the Medicaid patients residing in the nursing home. At present, Medicaid reimbursement for nursing homes is calculated based on the case mix scores of every patient in the facility, regardless of payor source. Since most of these non-Medicaid patients require skilled care, their higher acuity scores artificially inflate the facility's aggregate case mix score and overstate the cost of caring for the Medicaid population.

- Eliminating the GOL (General Operating Limit) which imposes an overall cap on nursing home reimbursement, and replacing it with individual ceilings on the various cost centers. The nursing home industry has been hostile to the GOL since it was first instituted three years ago. The Agency is considering abandoning the GOL when it adopts a new reimbursement system in July 1998, in favor of the approach used by most of the other states, which establishes specific reimbursement ceilings for the various cost categories in a nursing home's budget, which include nursing care, administration, dietary, etc.
- Eliminating ROE (return on equity). The current reimbursement system gives owners of for-profit nursing homes an allowance, representing a return on the equity invested in their facilities. The Agency believes that the rebasing process, which recognizes the costs of maintaining and upkeep of the physical plant, already provides sufficient incentive for owners to reinvest in their facilities. Therefore, additional financial rewards, such as ROE, are unnecessary. Moreover, other parts of the long-term care system, such as adult day centers or non-profit nursing homes, do not enjoy a return on equity.
- Adoption of a fair rental system for assessing a nursing home's property costs. The current reimbursement system encourages facilities to finance nursing home assets by borrowing rather than equity investment. A fair rental system would promote long-term ownership and discourage churning. Fair rental would also avoid large fluctuations in the property component of the rates, avert litigation commonly resulting from nursing home sales, and eliminate the need for the much reviled nursing home transfer tax.

VI. Conclusion

The study undertaken by the Agency of Human Services to evaluate the current reimbursement system for long-term care services has confirmed what many people long-suspected: Vermont has overbuilt its nursing home system to the detriment of community-based alternatives. Our history of chronically underfunding home and community-based services has forced countless elderly and disabled Vermonters to leave their homes and enter a nursing facility in order to receive appropriate medical care. As a result, Vermont lags behind the nation -- eighth worst in the country according to study conducted by the federal Administration on Aging -- in developing a flexible long-term care delivery system which responds to the widely-expressed preference of consumers to receive long-term care services in a home setting.

This study will result in a new reimbursement system that actively promotes home and community-based services, adequately funds community-based providers, yet assures that a reconfigured nursing home industry has the resources to continue providing high quality care to the frailest members of our population. The end product will be a flexible, versatile, multi-dimensional system affording consumers an array of choices and enhancing their quality of life.

Insert chart "Nursing Home and Other LTC Programs"