

Using the Medicaid Nursing Home Reimbursement System to Encourage Quality, Access and Efficiency

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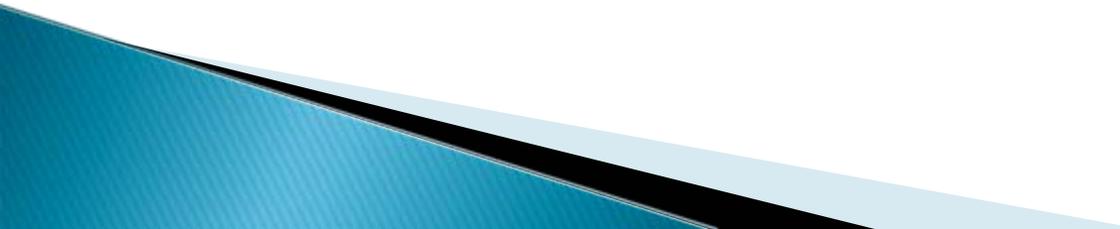
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Presented at the NCCNHR Annual Meeting, October 24,
2009

MEDICAID AND LONG TERM CARE

- ▶ Medicaid is the dominant purchaser of nursing home services in the United States. Medicaid recipients constitute 70% of all nursing home bed days.
- ▶ In 2007 Medicaid expenditures in the US were over \$136 billion of which 34% was spent on long term care. Of the \$46 billion spent on long term care, 44% went to the care of nursing home residents.
- ▶ Because it provides major funding for nursing home care, the ways in which Medicaid pays for this care have a major influence on how care is provided and how standards are (or are not) met by providers.

WHY IT IS IMPORTANT FOR ADVOCATES TO UNDERSTAND REIMBURSEMENT

- ▶ Providers always say they need more Medicaid money – is it true?
 - If a provider shows a loss does it mean he needs more money?
 - Do we know how much it costs to care for nursing home residents? Or How much it costs to maintain the highest level of functioning for deteriorating residents?
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WHY IT IS IMPORTANT FOR ADVOCATES TO UNDERSTAND REIMBURSEMENT

- ▶ Medicaid spending is a frequent target for state & federal leaders – crucial we know how money is spent and have recommendations for ensuring that limited funds are used to pay for quality care.
 - ▶ How we pay for nursing home care and how a state and federal government makes cuts affects:
 - Access
 - Quality
 - Efficiency
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MEDICAID PAYMENT OPTIONS

MEDICAID PAYMENT OPTIONS

- ▶ Retrospective
- ▶ Prospective
- ▶ Combination systems

HOW PAYMENT IS DETERMINED

- ▶ after the provision of care and is based completely on the costs incurred by the facility.
- ▶ rates are set in advance of care, regardless of actual costs the facility incurs during the rate year.
- ▶ rates are set in advance for some cost components and afterward for others based on actual costs.

CASE-MIX REIMBURSEMENT: A PROSPECTIVE SYSTEM

- ▶ MOST STATES (35) NOW USE CASE-MIX AS THEIR MEDICAID PAYMENT SYSTEM FOR NURSING HOMES
 - ▶ MEDICARE PAYMENTS FOR SNFS USE A CASE-MIX SYSTEM
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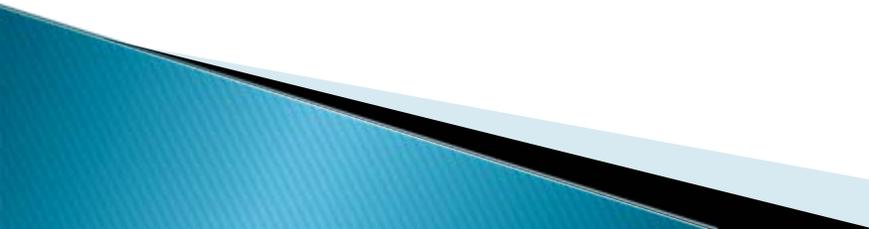
STATES USING CASE-MIX

- ▶ Arizona
- ▶ Colorado
- ▶ Delaware
- ▶ Georgia
- ▶ Idaho
- ▶ Illinois
- ▶ Indiana
- ▶ Iowa
- ▶ Kansas
- ▶ Kentucky
- ▶ Louisiana
- ▶ Maine
- ▶ Maryland
- ▶ Massachusetts
- ▶ Minnesota
- ▶ Mississippi
- ▶ Montana
- ▶ Nebraska
- ▶ Nevada
- ▶ New Hampshire
- ▶ New Jersey
- ▶ New York
- ▶ N. Carolina
- ▶ N. Dakota
- ▶ Ohio
- ▶ Oregon
- ▶ Pennsylvania
- ▶ S. Carolina
- ▶ S. Dakota
- ▶ Texas
- ▶ Utah
- ▶ Vermont
- ▶ Virginia
- ▶ Washington
- ▶ W. Virginia

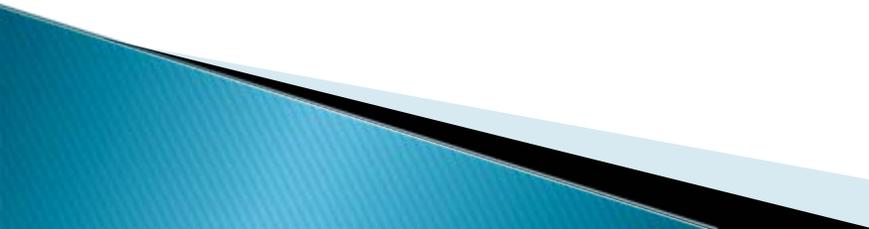
CASE-MIX

- ▶ Nursing homes are reimbursed for the care of their Medicaid or Medicare residents prospectively (before care is given) rather than retrospectively (after care is given).
 - ▶ Residents are assessed to estimate the amount of care (or resources) they will need and placed into a case or group with other residents based upon similar care needs.
 - ▶ Facilities are paid based upon the number of residents in each group or case.
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WHY DID MOST STATES SWITCH TO CASE-MIX?

- ▶ Improve access to care (for heavy care residents) by varying the reimbursement rate with the resident's condition.
 - ▶ Enhance quality of care by linking reimbursement to the acuity of care. Case-mix was to provide an incentive for nursing homes to reallocate resources, in particular clinical staffing, in ways that are more responsive to the needs of the residents they serve.
 - ▶ Improve efficiency and contain costs by paying prospectively.
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CASE-MIX HAS POTENTIAL NEGATIVE INCENTIVES

- ▶ Because facilities are paid higher rates for heavier care residents, there is a possibility that lighter care residents, those in the lower paying cases or groups, who still need nursing home care, may not be attractive to nursing homes and will not get the care they need.
 - ▶ Because residents who improve are reclassified into a lower paying category, there is a built in disincentive for facilities to help residents improve.
 - ▶ Because profits can be made by spending less than the prospective rate, facilities may not be spending what they need to in order to care for the residents they admit; they may not be more efficient, they may simply be withholding care.
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DIFFERENT WAYS TO ENCOURAGE ACCESS, QUALITY AND EFFICIENCY WITH CASE-MIX

▶ ACCESS

- “Add-ons” to the rate for certain types of residents
- Higher rates for certain types of residents
- Institute programmatic requirements

▶ QUALITY

- Give facilities additional money (on top of their standard reimbursement) for meeting specific performance goals (e.g., Pay for Performance (P4P))
- Tie a portion (or all) of facility reimbursement to achieving quality standards

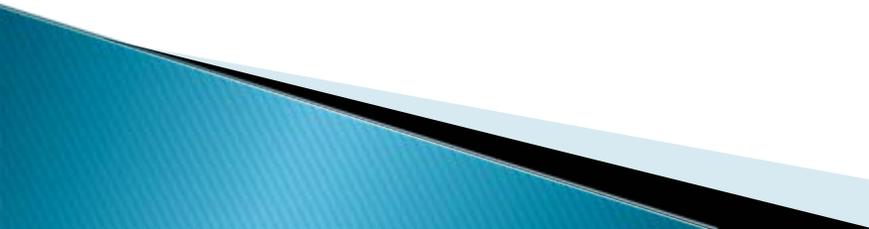
▶ EFFICIENCY

- Set rates based upon averages
- Set rates based upon “ceilings and floors”
- Limit expenditures in certain areas of reimbursement such as administrative costs

LTCCC STUDY OF CASE-MIX SYSTEMS

This study focused on how different states, using a case-mix reimbursement system, encourage access, quality and efficiency in nursing home care.

Key Questions:

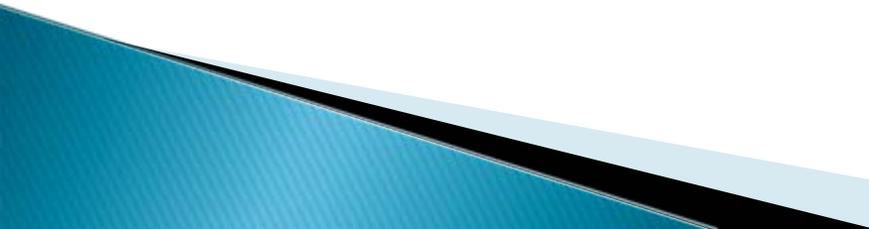
- ▶ How can the nursing home case-mix system be modified to better encourage quality care, access and efficiency?
 - ▶ How can we relate nursing home reimbursement to inspection and enforcement results?
 - ▶ How can we tie nursing home reimbursement to quality outcomes for residents?
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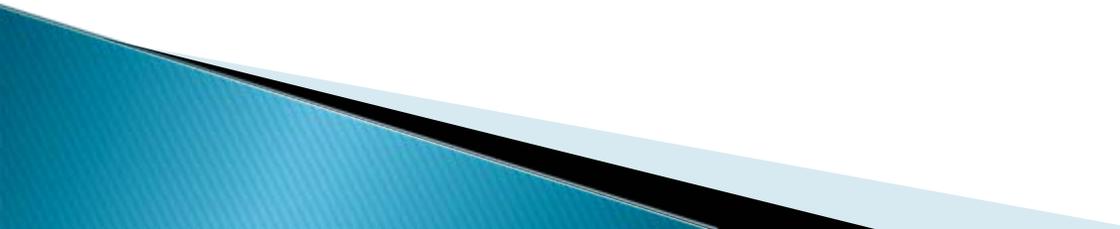
METHODOLOGY

- ▶ Detailed information was gathered on the characteristics of each of the 35 states' nursing home Medicaid reimbursement systems.
- ▶ Four main data sources were used: state statutes and regulations, provider manuals distributed by the states, information gathered from previously published scholarly articles and interviews with state officials in the seven case study states.
- ▶ Online surveys were developed and sent to ombudsmen and citizen advocacy groups in each of the 34 case-mix states researched (NY was excluded). Those surveyed were asked to convey their level of awareness of specific initiatives in their state and their impressions of how these initiatives have affected quality care.

METHODOLOGY

- ▶ Using the data gathered from our research and surveys, seven states were selected for further analysis as case studies. These seven states – Georgia, Kansas, Maryland, Minnesota, Mississippi, Texas, and Utah – were selected because of their unique initiatives for access, efficiency, and quality.
 - ▶ State officials responsible for implementing and administering their states' Medicaid reimbursement systems were contacted and phone interviews were held using uniform interview questions. Each interview lasted 30–60 minutes and was targeted at gathering information on specific initiatives which were linked to incentives for access, efficiency, and quality care.
 - ▶ The goal of the interviews was to determine what led these states to implement their initiatives, whether state officials felt they were successful, and if they would change any aspects of their system.
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METHODOLOGY

- ▶ All the data collected were analyzed and several follow up phone interviews were held to address any remaining questions on each state's reimbursement system.
 - ▶ Using information from the interviews with state officials, a survey for state ombudsmen and citizen advocacy groups in the seven case study states was developed. The survey asked the respondents to comment on the different initiatives and react to information collected from state officials.
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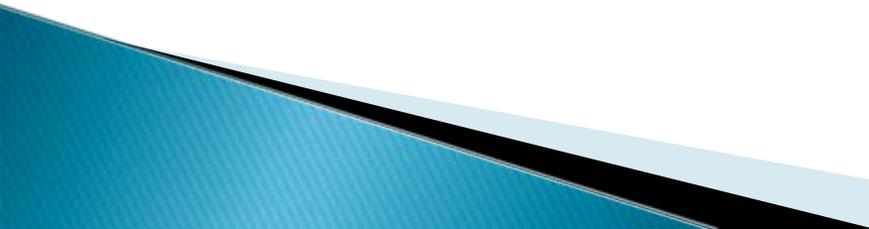
FINDINGS: ACCESS

- ▶ In order to encourage nursing home admittance, some states have given 'add-ons' to a facility's rate or have developed special rates for certain categories of residents that they consider hard to place or in need of more resources.
- ▶ Some states have programmatic requirements attached to these add-ons, in order to make sure that the added funds are going into care; others have given the add-ons just for admitting the resident.
- ▶ Some states have add-ons to encourage access for Medicaid residents and to encourage higher occupancy levels. Other states offer funds for special equipment for residents who need more expensive treatments.
- ▶ Typical add-ons are for: (1) ventilator dependent residents; (2) brain-injured residents; and (3) residents with dementia or Alzheimer's.

EXAMPLES of ACCESS INCENTIVES

- ▶ Georgia gives facilities a rate adjustment for admitting residents with moderate to severe cognitive impairment. In order to qualify for the rate adjustment facilities need only admit such residents. There are no programmatic requirements attached such as special staffing or training.
- ▶ Kansas pays facilities an add-on to their rates for residents who are ventilator-dependent. In order to qualify, the facility must develop a care plan for each ventilator-dependent resident which is subject to outside review.
- ▶ Maryland gives facilities an enhanced rate for certain ancillary services such as decubitus ulcer care (Stages III and IV – if ulcer is not a result of poor care), tube feeding, communicable disease care, central intravenous lines, and ventilator care. Many programmatic requirements are mandated.
- ▶ Mississippi gives providers an incentive to build Alzheimer units by giving higher case-mix weights for Alzheimer residents in certain RUGs categories who are cared for in an Alzheimer unit. In addition, Mississippi gives facilities with an Alzheimer unit a higher fair rental value as part of its property reimbursement.
- ▶ Texas has an add-on for ventilator-dependent residents. Facilities are not required to meet any specific criteria in order to receive the supplement other than admitting ventilator-dependent residents.

ISSUES RELATED TO ADD-ONS AND SPECIAL RATES

- ▶ How is the need for these determined?
 - ▶ How is success (in terms of improved access) evaluated?
 - ▶ Should states require facilities to do more than just admit a resident to receive the add-on or special rate?
 - ▶ Are states monitoring the effect of their add-ons or special rates on quality?
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FINDINGS: QUALITY

- ▶ Some states encourage quality of care by setting maximum reimbursement allowed higher on direct care expenses than for other expenses, such as in-direct expense, or they have put maximums only on in-direct expenses.
- ▶ Most states do not encourage efficiency in the direct care areas because doing so would, in effect, encourage them to spend less of their reimbursement on resident care.
- ▶ Some states even require facilities to spend any savings (profits) they made on direct care reimbursement on the direct care of their residents or return it to the state.
- ▶ Some states have also used pools of Medicaid funds from outside the structure of traditional reimbursement funds to give to eligible nursing homes to encourage quality. These include grant programs for special projects improving quality; additional funds for performing well (“pay-for-performance” and other incentives to promote quality).

SELECTED EXAMPLES

- ▶ Maryland pays facilities a higher rate for two months when a resident improves enough to move to a lower-paying category to encourage facilities to help residents improve and Maryland does not pay for care for stage III and IV decubitus ulcers if it is shown that the ulcers were caused by poor care in the facility.
- ▶ Georgia's add-ons for quality require facilities to meet both clinical and quality of life criteria. Georgia gives facilities an add-on to their rate if they are better than the state averages on:
 - (1) the percent of high risk long-stay residents who have pressure sores; (2) the percent of long-stay residents who are physically restrained; (3) the percent of long-stay residents who have moderate to severe pain; and (4) the percent of short-stay residents who have moderate to severe pain; performance in non-clinical areas such as (1) staff retention; and (2) use of resident satisfaction surveys.

SELECTED EXAMPLES

- ▶ Minnesota will be tying reimbursement directly to quality by using quality scores to develop limits on certain cost centers. It permits more spending if quality is high. The higher the facility's quality score, the higher its cost limits will be. This initiative is in current state law but will not be enacted for a number of years.
- ▶ Iowa gives additional reimbursement to a facility that meets certain criteria such as:
 - Performance on surveys
 - Number of nursing hours
 - Resident satisfaction scores
 - Staff retention
 - Occupancy levels above 95 percent
 - Presence of chronic confusion or dementia units
 - Low use of contracted nursing
 - Resident advocacy committee resolution rates.

SELECTED EXAMPLES

- ▶ Kansas gives facilities a per diem add-on ranging from zero to three dollars if they meet certain quality and efficiency incentives.
 - Case-mix adjusted nurse staffing ratio
 - Operating expense
 - Staff turnover
 - Staff retention
 - Occupancy (total and Medicaid)
 - Survey findings
- ▶ To encourage spending in the direct care area, Louisiana sets a floor for Direct Care and Care Related costs centers. Any facility that spends less than the floor must reimburse Medicaid for the difference between their spending and the floor.
- ▶ Louisiana also gives an add-on to facilities that convert a semi-private room to a private room for use by a Medicaid resident and Louisiana has a higher ceiling set for Direct Care costs than for other cost centers.

SELECTED EXAMPLES

- ▶ In Maine if a facility has been found not to have provided quality of care, reimbursement is reduced to 90 percent of the rate until deficiencies are corrected; add-ons are given for recruitment and retention of staff and a cap is placed on administrative costs.
- ▶ Minnesota gives additional reimbursement to a facility that meets certain criteria such as:
 - Quality indicators
 - Staff turnover and retention
 - Low use of temporary staff
 - Quality of life
 - Inspection findings.
- ▶ New Jersey has created a Nursing Home Quality of Care Improvement Fund to create a pool of money to be used in a grant program to improve quality care, staff recruitment and retention and increases in salaries.

SELECTED EXAMPLES

- ▶ Ohio has a combination of a quality and efficiency incentives:
 - Family satisfaction
 - Resident satisfaction
 - Staff retention (above peer group average)
 - Occupancy rate
 - Medicaid utilization rate
 - Case-mix scores
 - Nursing hours (above state average)
 - Inspection results
- ▶ South Carolina gives an add-on for staff to act as escorts when residents need to go to out of the facility for a non-emergency service.
- ▶ South Dakota uses a point system to determine the maximum salary of a facility's owner, which awards a higher reimbursable salary for owners who have more experience in the health care field and who have higher levels of education.

SELECTED EXAMPLES

- ▶ Utah's initiative focuses on the need for quality improvement plans. Utah sets aside \$1,000,000 annually to reimburse nursing facilities that have a quality improvement plan which includes a number of unique areas:
 - The involvement of residents and family.
 - A process of assessing and measuring the plan.
 - Quarterly customer satisfaction surveys conducted by an independent third party.
 - A plan for culture change with an example of how the facility has implemented culture change.
 - An employee satisfaction program.

ISSUES RELATED TO QUALITY

- ▶ Are additional funds going to facilities to do what they are already being reimbursed for?
- ▶ Are the quality pools or incentives part of the Medicaid reimbursement pool rather than being additional or bonus funds? The goal is to move the reimbursement system from one based upon facility charges to one based upon outcomes.
- ▶ Do the criteria for receiving quality incentives include resident and family satisfaction? Worker satisfaction? Worker retention and low turnover?
- ▶ If criteria include staffing numbers, are the numbers self-reported or validated records? Do they include contract staff?
- ▶ If they include satisfaction rates, how is this determined?
- ▶ Is the state evaluating the success of its incentives?

FINDINGS: EFFICIENCY

▶ ENCOURAGING EFFICIENCY

◦ SETTING LIMITS

- Some states pay facilities an **average rate** of all facilities in the state or in their peer group: geographical location, size, etc.
- This may create an incentive for facilities to keep their costs at or below the average in order to avoid an loss or to make a profit.

FINDINGS: EFFICIENCY

◦ SETTING LIMITS CONTINUED

- Some states set ceilings (or caps) and sometimes floors on costs. In such a system, facilities spending above a ceiling or below a floor will receive that ceiling or floor rather than a state or peer group average.
- This may encourage facilities to keep their costs below the ceilings or caps in order not to incur a loss or below the floor to make a profit.
- Some states set higher ceilings for direct care costs than for indirect care costs.

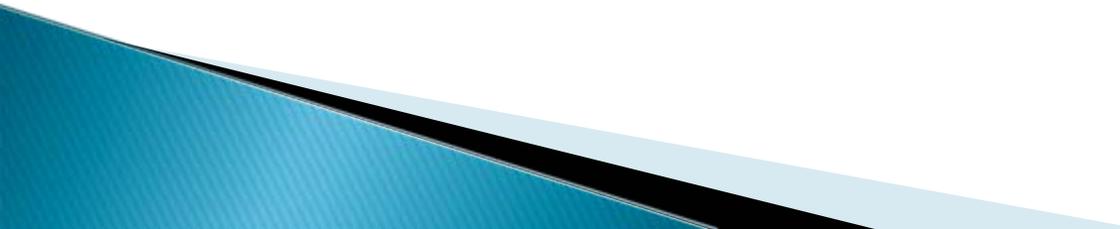
FINDINGS: EFFICIENCY

- GIVING BONUSES

- Generally, states using this method give facilities that stay below the ceiling a percentage of the difference between the ceiling and their costs.
 - Most of the states using such bonuses do not include the direct care cost center for such an incentive because they do not want to encourage reduced spending on direct care .
 - As shown above in the Access and Quality Incentive sections, some states have incentives to actually encourage spending on direct care.
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FINDINGS: EFFICIENCY

▶ OTHER METHODS:

- Some states limit certain costs such as administrative costs.
 - Some states require the facilities to maintain a certain occupancy level. They believe that this enhances efficiency by spreading out the fixed costs over a greater number of residents, leading to a lower per capita average fixed cost.
 - Some states give bonuses for making changes to a facility that will make it more efficient such as energy conservation renovations.
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SELECTED EXAMPLES

- ▶ Delaware gives an efficiency incentive in the Support and the Administration cost centers to facilities that maintain costs below the ceiling.
 - It does not provide the incentive in the Direct Cost center.
 - It has set a 90 percent occupancy level for the calculation of rates.
- ▶ Georgia allows facilities to earn an efficiency incentive in each of its five cost centers (including direct as well as indirect care) if facilities projected costs are below the ceiling.
- ▶ Kentucky reimburses facilities at a statewide median rate.

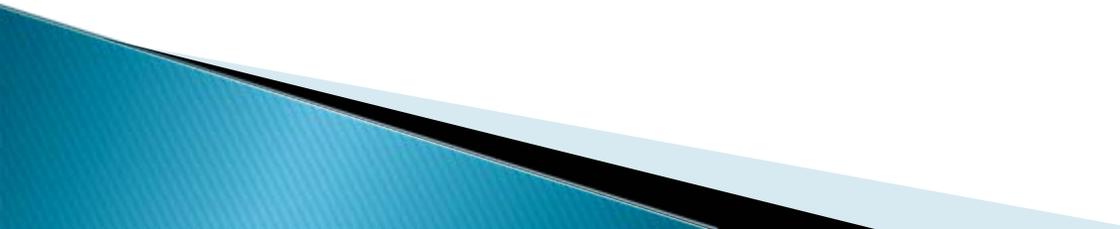
SELECTED EXAMPLES

- ▶ Maine places a ceiling on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation. Maine also permits depreciation for a number of energy efficient improvements such as: insulation, energy efficient windows or doors, shades and shutters, caulking and weather stripping.
- ▶ Minnesota gives an efficiency incentive in all the cost centers except the direct care cost center and has a competitive process for the years 2008 and 2009. Facilities can apply to the state with specific quality and efficiency improvement projects and the best proposals (as determined by an analysis performed by the state) will receive state funds.

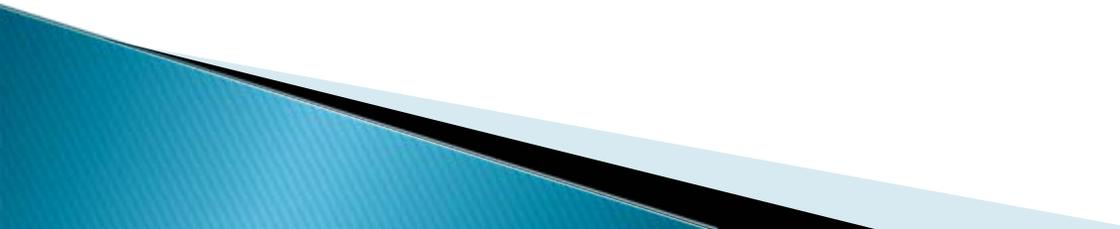
SELECTED EXAMPLES

- ▶ Nebraska sets a ceiling on Direct Nursing care cost as a percent of the median peer group cost.
- ▶ New York currently uses both ceilings and floors. Its ceilings are the same for all cost centers. Its floors are lower for direct care costs.
 - Major changes have been proposed:
 - Removal of the ceilings and floors
 - Paying facilities a regional median rate
 - Reducing bed hold payments to 75 percent of the Medicaid rate.
- ▶ Pennsylvania has placed a cap on the administrative costs at 12 percent of total facility costs.

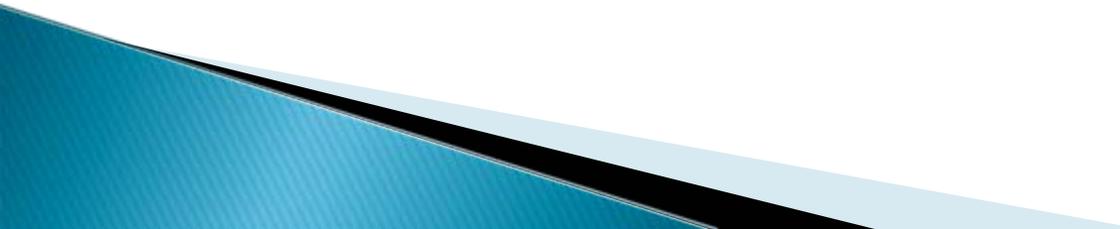
SELECTED EXAMPLES

- ▶ Vermont gives an adjustment for costs related to installation of energy conservation devices or other efficiency measures.
 - ▶ West Virginia may deny a facility the efficiency incentive if they have any deficiencies during the reporting period.
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ISSUES RELATED TO EFFICIENCY

- ▶ Do cost containing incentives encourage less quality?
 - ▶ Are states evaluating the success of their incentives?
 - ▶ Are states monitoring the effect of efficiency incentives on quality?
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RECOMMENDATIONS

- ▶ The following recommendations are listed separately for access, quality and efficiency.
 - ▶ However, it is crucial to remember that the different incentives are interrelated. For example, incentives for efficiency may affect quality and as states implement these recommendations it is important for us to think about the full impact of any incentive.
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RECOMMENDATIONS: ACCESS

- ▶ States should not give extra funds to facilities to admit certain residents without:
 - Identifying a specific need
 - Setting goals for the incentive
 - Mandating both programmatic requirements and positive outcomes
 - Frequently evaluating whether the incentive is meeting its goals
 - Dedicating resources to make sure that such evaluations are carried out for as long as the incentive is in place.

RECOMMENDATIONS: QUALITY

- ▶ States should encourage spending in direct care.
 - ▶ Links must be made between reimbursement and quality care through the states' nursing home surveillance system and enforcement systems.
 - ▶ States should begin to move their reimbursement systems from one focusing only on facility expenses to one more focused on quality by moving Medicaid funds over time into a pool of money to be distributed to nursing homes based upon a variety of positive outcome indicators.
 - ▶ Facilities with major care problems should be disqualified from programs that provide additional funding.
 - ▶ All programs should be continually evaluated. Are they successful in meeting their goals? For this, it is crucial that resources be dedicated to evaluation.
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RECOMMENDATIONS: EFFICIENCY

- ▶ States should be encouraging spending in direct care, most of which relates to direct care staff, not discouraging it.
 - Ceilings and floors should be used for the direct care costs rather than statewide or regional averages
 - Facilities spending below the floor in direct care must be required to spend the difference between the floor and their costs on direct care or return the funds to the state
 - States should encourage spending in direct care areas by not permitting efficiency payments in their direct care cost component.
- ▶ Efficiency payments should be considered only in those non direct care areas not related to care or quality of life.

RECOMMENDATIONS: EFFICIENCY

- ▶ States should create incentives for facility improvements which are cost efficient, such as the installation of “green” improvements. While states will incur immediate costs, they have the opportunity to save money in the long run.
- ▶ States should have a formal process in place, with a source of funding, to evaluate the effect of the structure of their system on efficiency and quality. Have costs gone down? Has quality been compromised as costs have been contained or gone down?
- ▶ In order to save money, states should consider capping certain costs as a percentage of total costs. Such caps should be put on total indirect costs (or costs within this category less related to care such as administrative costs, owner compensation, etc...) to make sure that spending in these areas is not disproportionate to the amount being spent in direct care.

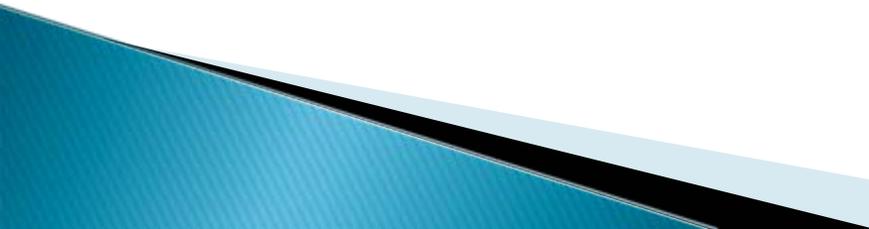
TO DOWNLOAD A FREE COPY OF THE ENTIRE REPORT

- ▶ www.ltccc.org or www.nursinghome411.org
- ▶ Click on *[Modifying the Case-Mix Medicaid Nursing Home System to Encourage Quality, Access and Efficiency](#)*

HOW CAN YOU ADVOCATE FOR CHANGES?

- ▶ Become knowledgeable
 - Learn about your state's payment system
 - ▶ Educate others
 - Publish briefs on what you would like to see in your state's system to improve access, quality and efficiency
 - Educate your state leaders on the importance of the reimbursement system encouraging quality
 - Educate the public by putting information in your newsletters and on your website
 - Educate the public by writing letters to the editor of local papers; write articles for newsletters of other organizations; and write articles or op-eds for local papers.
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HOW CAN YOU ADVOCATE FOR CHANGES?

- ▶ Make sure you participate in any discussion of reimbursement
 - Work to convince state leaders of the need for consumer involvement
 - Discuss the issue with your state legislators
 - Discuss the issue with your governor
 - Discuss the issue with staff of the agency responsible for reimbursement and bringing together advisory committees
 - Work with media to get out the word on the importance of consumer involvement
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HOW CAN YOU ADVOCATE FOR CHANGES?

- ▶ Bring other consumer groups together to fight for changes
- ▶ Bring examples from other states (use our report) to the attention of your state leaders
- ▶ Promote grassroots action
 - Develop steps the public can take to advocate for your ideas
 - Urge individuals to:
 - Write letters (if possible, using sample letters you have written) to policy makers in your state – legislators, the governor, aging agencies, health department, etc.
 - Write letters to the editor of local papers
 - Meet with their political representatives