

Appendix 4

Commission on Health Care Facilities in the 21st Century

BRIEFING ON LONG TERM CARE REIMBURSEMENT and NON-INSTITUTIONAL CARE MODELS

Introduction

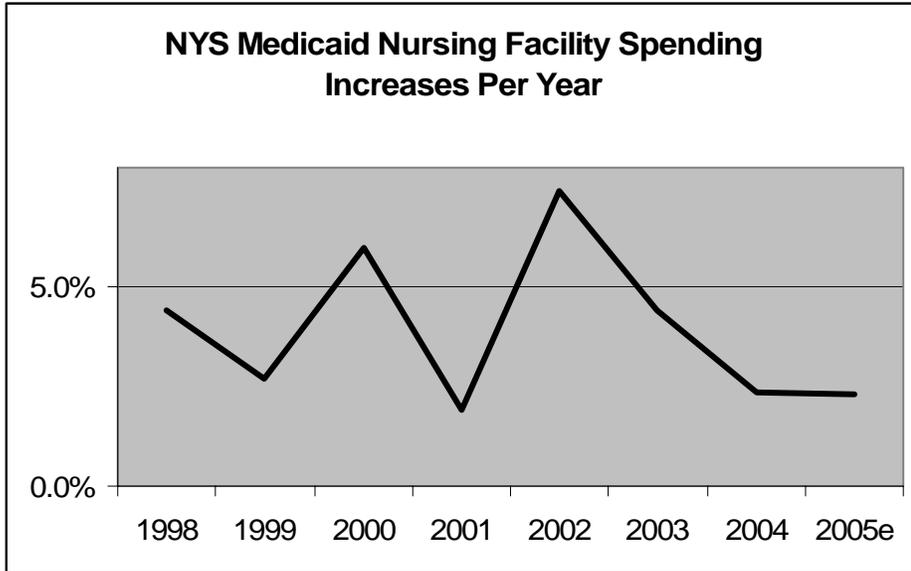
The structure of the health care delivery system is determined in large part by financing. Changes made as a result of Commission recommendations must be supported with an appropriate reimbursement system. Although reimbursement reform is beyond the Commission's core statutory charge, members can include non-binding reimbursement recommendations in their final report. Therefore, this paper describes 1) the current New York State Medicaid reimbursement system for long-term care 2) options under consideration to alter the current system, and 3) broader ideas for expanding the available spectrum of long term care options.

New York State Medicaid Spending on Nursing Homes and Other Long Term Care

Medicaid is the dominant payer for nursing homes. It pays for 78% of all nursing home days in the state¹. New York spent \$6.2 billion in FY 2004 on nursing facilities alone, or about 15% of the total state budget. By any measure, New York State leads the country in its spending for nursing facilities:

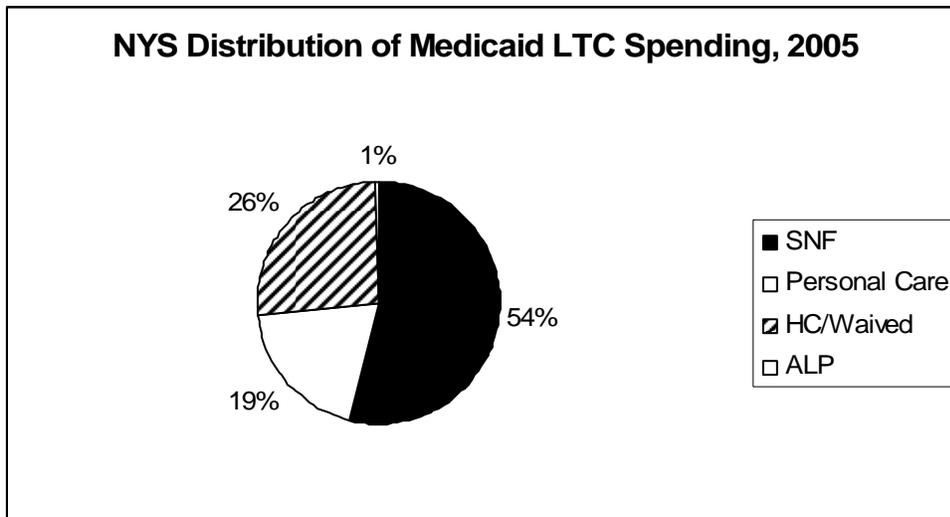
- NY spends over \$2 billion more annually than the next highest state in total dollars.
- NY spends more than 11% higher than the next highest state on spending per nursing home resident.
- NY has the largest total number of nursing home residents, despite ranking #3 among states in its total number of citizens ages 75 and older.
- New York spends more than any other state on a per-capita basis for nursing facilities.²

Spending on nursing facilities continues to increase, even if the rate of growth may be slowing:



Source: Preserving Long Term Care for the Long Term Future, New York Association of Homes and Services for the Aging, December 2003; and New York State Quarterly and Annual Medicaid Reports

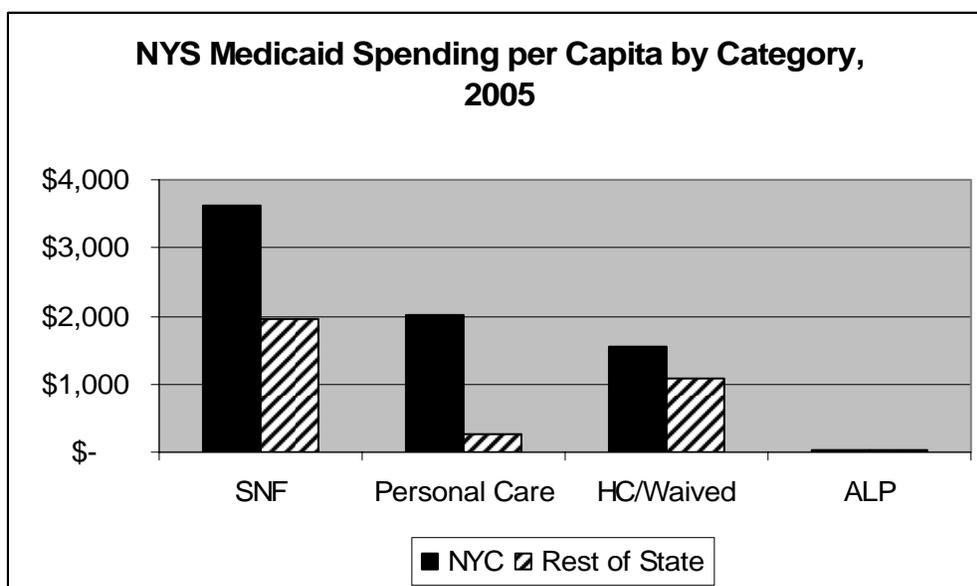
In addition to supporting nursing facility care, the New York State Medicaid program also supports a variety of non-institutional long-term care services, including long-term home health care, personal care services, medical day care, and some assisted living. New York State ranks 6th among states in its total number of Aged and Disabled Medicaid beneficiaries.³ New York State actually has one of the lowest proportions of nursing facility spending to total long-term care spending (54%), meaning that it is among the highest in supporting non-institutional options.⁴



Source: Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service by Category of Service and Aid Category, July-Sept 2005

Combining the Personal Care Program, nursing facility payments, home health and other “waived” services (comprising long-term home care and adult day health care), New York spent nearly 11.8 billion in fiscal year 2005 for long-term care services.

A major aspect of New York’s non-institutional long-term care system is the Personal Care Program. This program provides home attendants to primarily assist with activities of daily living such as bathing or feeding, but does not provide much clinical care. In 2004, NYS spent \$2.2 billion on this program—with about 85% of expenditures in New York City. All other home- and community-based services spending in the state totals under \$2 billion a year.⁵ Not only does New York City consume the bulk of the Personal Care program expenditures, but it out-spends the rest of the State in all long-term care expenditure categories.



Source: see chart above

The unbalanced spending for non-institutional care may be due in part to a greater willingness by the New York City local government to support these expenditures, whereas other local governments more stringently control access to personal care, home care, and day care. The greater per-capita spending on skilled nursing facilities in New York City may be due in part to differences in wage structures.

Current Nursing Home Medicaid Reimbursement Methodologies

New York State’s reimbursement methodology for nursing homes is fairly traditional and bears similarities to many other states. New York Medicaid pays nursing home providers largely on a “facility-specific” basis, utilizing the facility’s costs and circumstances to determine price. Each skilled nursing facility in New York State is paid a Daily Rate for each day a resident spends in the facility. The daily rate is expected to cover all room, board and care services, including

nursing care, meals, housekeeping, therapies, recreation, medical care and supplies. Up until this year, the daily rate was to include pharmacy costs, but Medicare Part D now covers that for Medicare-eligible residents.

The calculation of the Medicaid daily rate is based on four general “buckets” of expenses: direct, indirect, capital, and non-comparable costs. Each bucket is explained below, along with the calculation parameters:

- Direct Costs: Direct costs comprise the clinical, therapeutic, and supportive care expenses of the facility, specifically the salaries and benefits for: nursing, nursing assistants and therapists, social services, as well as laboratory, radiology, and ancillary service providers. The direct component of the daily rate is calculated based on the facility’s direct expenses as well as the case-mix score of all residents (see more on case-mixing below) which determines the “ceiling” up to which the facility’s direct costs can be paid.
- Indirect Costs: Each facility is required to provide all the room and board services for residents (such as food service, housekeeping, facility maintenance) as well as supervision and administration, utilities, insurance, etc. These are likewise subject to a ceiling, according to their Peer Groups. The peer groups are currently defined as free-standing or hospital-based, and over or under 300 beds. The ceilings for hospital-based and 300+ bed institutions are higher than for their counterparts.
- Capital Costs: Capital cost reimbursement calculations are entirely based on the facility’s costs. For each major capital expense, the facility must submit a Certificate of Need (CON) application. The interest and depreciation for these CON-approved capital expenses are divided by the facility’s resident-days and added on to the daily rate. Thus, the capital costs are “passed-through” directly to Medicaid. A ceiling is effectively imposed at the front-end, meaning that capital project CONs are subject to a per-bed cap or else not approved.
- Non-comparable Costs: Many facilities provide staff or services beyond the basic direct costs, such as salaried physicians, psychologists, nurse practitioners, swallowing disorder specialists, etc. These costs (which must be approved by the Department of Health) are also passed-through and added on to the daily rate.

The daily rate is the sum of these four components, with additional technical adjustments to determine the final facility daily rate.

As mentioned, all these calculations are based on the facility’s costs. However, this is not reviewed annually. Rather, the facility costs are determined in the Base Year. The default base year for all facilities in the state is 1983. Some facilities—those that have undertaken significant capital renovations, expansions or replacements, as well as those facilities that have changed ownership—utilize a base year from the time of their capital project or turnover.

Another key element in the daily rate calculations is the Case Mix. Currently, each facility goes through a resident review twice yearly; the residents are categorized along a spectrum of 16 resident-types called Resident Utilization Groups, or RUG II. Each category carries a service-intensity weight, so that the final case mix for the facility is calculated by multiplying the number of residents in a category by the category weight, and summing the results. (For the RUG II categories and case mix weights, see Appendix A.) The resulting case mix score determines the direct cost ceiling.

These service intensity weights assigned to each category are based on a Medicare time-and-motion study of nursing and therapy services. Thus, the weights may not always adequately reflect resource utilization, particularly for those resident types that use fewer therapy services but are still resource-intensive, such as those with cognitive impairments.

Along those lines, New York State has recognized that there are some resident types that are so resource-intensive or specialized that the basic Medicaid methodology described above is not applied, and instead the facility receives a distinct rate for its Special Care Units. Special unit rates currently available are: AIDS, Traumatic Brain Injury (TBI), Ventilator-Dependent (Vent), Pediatrics and Neuro-Behavioral (psychiatric care which requires locked units).

In addition to receiving the Medicaid daily payment for every Medicaid resident in the facility, the facility receives a Medicaid daily payment for every Medicaid resident who is discharged to a hospital or on a therapeutic leave of absence, to reserve a place for the resident upon his/her return. These daily payments for absent residents are called "Bed Hold" payments, and facilities are eligible to bill for a reserved beds only when the vacancy rate in the licensed capacity is less than or equal to 5.0%.

The daily rate varies by payer. For New York State Medicaid, the daily rate is calculated specific to each facility, based on that facility's costs—as submitted in its Nursing Home Cost Report—and the mix of residents it serves. As a result, there is a great range of Medicaid daily rates throughout the State, varying more with facility and less so with the type of residents cared for within them:

2004 Medicaid Daily Rates for Facilities, by Commission Region

Region	Median	Low	High
Central	\$ 143.83	\$ 91.70	\$ 245.07
Hudson Valley	\$ 179.67	\$ 131.52	\$ 324.93
Long Island	\$ 213.77	\$ 160.87	\$ 273.46
NYC	\$ 217.89	\$ 146.37	\$ 299.24
Northern	\$ 149.46	\$ 116.17	\$ 203.31
Western	\$ 147.04	\$ 108.29	\$ 205.11

Source: Commission on Health Care Facilities in the 21st Century Analysis of 2005 Medicaid Daily Rates

Medicare: A Payer of Growing Importance

Increasingly, Medicare has become a significant payer for nursing homes, building a business for “sub-acute care” and “short-term rehabilitation” following a qualifying hospital day, where specific clinical and therapeutic goals are being pursued in the facility. Medicare also pays a daily rate, but the calculations are more straight-forward. Utilizing the RUG III categories (see Appendix B) instead of the RUG II categories, each category carries a resident-specific price, which is based on the service-intensity and is adjusted for regional costs. The Medicare category price is expected to cover all direct, indirect, capital and non-comparable costs for that resident.

Nursing Home Medicaid Reimbursement: Issues and Options

There are incentives and disincentives within the current nursing home reimbursement methodologies which may have unintended consequences. As a strong and vital skilled nursing facility industry is important in order to maximize the New York State health care delivery system, there are number of issues and options that can be considered:

- **Issue:** A 1983 base year is out-dated. Clinical advances, nursing practice changes, technology expansion, more rapid resident turn-over, and many other changes have transformed the expense structure of just about every facility in the state. The industry’s trade associations estimate that the 1983 base year resulted in an average loss of \$21.23 for every resident-day.⁶ Approximately 50% of NYS facilities are still reimbursed by the 1983 base year.
 - **Option:** Update the base year to better reflect current nursing facility operations. While widely acknowledged to be necessary, an update to the base year could result in a sizable increase in Medicaid spending on nursing homes. (NB: see the following section on reforms made in the 2006-07 budget)

- **Issue:** There is uneven access to base year updates. Moreover, the “carrot” of updating the base year may encourage capital expenditures and facility turnover that may not have been necessary otherwise.
 - **Option:** Raise the base year every set number of years and eliminate specific facility base year updates. This change would: 1) enable ongoing changes and improvements

to be compensated; 2) maintain base equity across all providers; and 3) avoid an outdated base year in the future. However, advance knowledge of which year will serve as the base year could lead facilities to increase costs during that particular year, perhaps unnecessarily, to maximize their future reimbursement. Doing so could replicate the problematic incentives that existed under retrospective reimbursement. (NB: see the following section on reforms made in the 2006-07 budget)

- **Issue:** The RUG II classification system includes only 16 categories, whereas the RUG III system (the “next generation” classification system, utilized by Medicare and a number of other states—see Appendix B) includes 53, and can therefore better distinguish among resident types and costs.
 - **Option:** Utilize the RUG III classification system. More categories allow better matching of residents to resource weights. Moreover, utilizing the RUG III system eliminates the outdated scoring tool called the PRI, in favor of the Medicare tool (MDS) that is already required. Providers would need to in switching Medicaid information systems to the new system. (NB: see the following section on reforms made in the 2006-07 budget)
- **Issue:** The current peer groupings include greater than or less than 300 beds and hospital-based or not. Yet other characteristics that have been cited as contributing to higher cost do not have rate ceiling adjustments, such as having fewer than 100 beds or having a very short average-length-of-stay.
 - **Option:** Reexamine the appropriateness of the peer groups utilizing available information to determine the factors that contribute to higher costs. Should new peer groups emerge, there could be a transition period to assure the stability of facilities that have pursued strategies around the existing peer groupings.
- **Issue:** There are nursing-home-eligible individuals throughout the state who have mental health issues, but who do not require a locked unit. Because there is no special care unit or payment rate for these individuals, some do not easily find a facility to care for them and can often linger in hospitals. The same is true for very-obese individuals who require bariatric care.
 - **Option:** Implement special care rates or daily add-ons for Behavioral Step-Down and bariatrics. Doing so would encourage facilities to admit these hard-to-place costly types of residents. While this improves the overall efficiency of the health care system, the financial burdens increase for New York State Medicaid while gains are realized by hospital providers and Medicare. (NB: see the following section on reforms made in the 2006-07 budget)

Nursing Home Reimbursement Reforms in 2006-07 Budget

Several of the issues raised above have been addressed in the recently-passed budget. Most significant is the agreement to re-base all facilities to a 2002 base year, phased in over 4 years. After that, facilities will be re-based every 5-6 years, referencing one of the three previous years. In addition, this reform adds some equity to the system: no further facility-specific re-basings will be allowed. Other reforms include:

- Utilization of RUG-III instead of RUG-II.
- Per diem adjustments for: 1) early dementia in low-scoring categories; 2) dual-diagnoses of cognitive and behavioral issues; and 3) bariatrics (high body-mass-index).

Broader Reimbursement Reform: Shifting the Payment Paradigm

The options discussed above preserve the “facility-specific” pricing model, calculating a daily rate for every resident in a facility based on that facility’s costs, peer grouping, and the average of its residents’ case-mix. Disadvantages of the facility-specific paradigm include:

- Payment based on the case-mix *average* rather than the individual’s case category simultaneously mutes the disincentive to admit low-need individuals and dampens the incentive to admit high-need individuals
- Facility-specific payment means that the same individual can cost Medicaid very different amounts, depending on where the person is admitted.

Some states have adopted “resident-based pricing” wherein each resident is assessed and scored at regular intervals and upon a change in their condition. Each score is associated with a specific payment level and reimbursement is better matched to the care needs of an individual. Thus, nursing facilities have fewer reasons to shun high-need residents because they receive higher payments for individuals that need more services.

In some states, the resident’s score is tied to only the direct care component of the rate. In others as well as in the Medicare nursing home reimbursement system, it includes both direct and indirect costs. Maine uses a Resident Assessment Instrument, classifying residents into one of 44 groups according to their conditions and the resources required for care in order to calculate a per diem for direct patient care costs. In Texas, residents are classified into one of 11 Texas Index for Level of Effort (TILE) groups, each with its own rate. Several states currently use or are in the process of converting to the 53 RUG-III categories for nursing home reimbursement, including: Florida, Idaho, Indiana, Kentucky, Mississippi, New Hampshire, North Dakota, Ohio, Pennsylvania, Vermont, Washington, and West Virginia.

While “resident-based pricing” offers many advantages, there is not yet established a direct correlation between case-mix payment and quality of care. In theory, it is also possible that this system can discourage rehabilitation of residents that would result in lower payments.

Another option that exists in a few states is “flat-rate” payment, following the concept behind managed care’s capitated payment approach. Nursing home daily rates are set in advance, independent of an individual facility’s costs or actual resident mix, and are typically based on the cost experience of all facilities in a large geographic area such as California. Since providers are at risk financially if their costs exceed payments, an incentive to provide care at a cost below the set rate is created. If payments should exceed a facility’s costs, the facility may then keep the surplus as profit.

However, due to this strong incentive for cutting costs, facilities may find it to their advantage to make reductions that can decrease quality of care (ie, decrease staffing levels, reduce quality of meals). Additionally, this system creates incentives for facilities to admit lower-acuity residents who need less care, since they receive the same payment regardless of the time and resource investment needed for the resident.

Supporting Non-Institutional Care Models

While nursing home reimbursement methodologies and related issues are quite complex and require attention, it is important to remember that nursing homes are only one part of the long-term care continuum. To create a future system where “the right person is served in the right setting at the right price,” consideration should be given to issues and opportunities beyond the walls of the nursing home.

As mentioned, New York State already supports a good deal of non-institutional long-term care (also called “home- and community-based services, or HCBS). Beyond the Personal Care program, alternatives currently supported by Medicaid are:

- **Long Term Home Health Care Program (LTHHCP)**: This program operates under a specific Federal Medicaid waiver and is also known as "Nursing Homes Without Walls." LTHHCPs may only be established by independent Certified Home Health Agencies (CHHAs), hospitals, and nursing homes. LTHHCPs offer health care and support services to the disabled and chronically ill who are medically eligible for admission to a nursing home, but who choose to be maintained at home. These programs provide a full range of professional and aide level health care services to those in need over a long period of time. Expenditures for patient care in the program are capped at 75% of the average payment rate for nursing home care; however, exceptions exist which require case-specific approval for expenditures of up to 100% of the nursing home payment for patients with special care needs. The program is managed via a Department of Health (DOH) need methodology that determines how many “slots” can operate in each county and the local department of social services then controls individual admission to existing slots.

- Certified Home Health Agencies (CHHAs): These agencies provide care and support services to individuals who, for the most part, have home health care needs for a limited duration. CHHAs provide nursing and home health aide services, and provide or arrange for other professional services, including physical and occupational therapy, speech pathology, medical social work and nutrition services. CHHAs participate directly in both the Medicaid and Medicare programs. Most of the CHHAs reimbursement is through Medicare and/or Medicaid.
- Adult Day Health Care Program: This program operates in a Day Center with a specific number of “slots” per day. Like the home health program, each individual receives a care plan specifying the number of days they should attend the Center, along with the services to be received when they are there. The services can include not only a meal and recreation, but also nursing interventions, personal care (like bathing), and physical and occupational therapies. The program must be sponsored by a nursing home, and then Medicaid pays 65% of the nursing home’s daily rate for each registrant-day. The Medicaid rate includes door-to-door round-trip transportation for every day the individual attends; the transportation service can include Attendant assistance to help get the individual from their home into the van and back again.
- Medicaid Assisted Living Program (ALP): Like private-pay assisted living, this program provides room, board, housekeeping, personal care, and nursing care services to nursing-home-eligible individuals. The ALP must be contained in a licensed adult home or enriched housing program (the two licensure categories for adult supportive housing in New York). The resident’s SSI pays for the adult home or enriched housing component, covering room, board, up to 3.5 hours of personal care, and service coordination/oversight. Medicaid then pays a daily rate for home care services, according to the resident’s RUG II category, at 50% of the regional RHCF rate. The additional services—additional personal care, nursing care, medication management or administration, and sometimes physical, occupational, or speech therapy—are provided by a licensed home care services agency for that daily rate. There are only 4,200 ALP beds allowed in the State, per an administrative cap on the program.

Medicaid Assisted Living may be a more viable alternative to nursing home care for some individuals. Home care and day care do not provide 24-hour supervision, and if an individual requires that and does not have a family caregiver able to take responsibility in the “off-hours,” out-of-home placement is necessary. However, nursing facility care may be too intensive for their needs. A 1999 study by the NYS Department of Health found that roughly 5% of all nursing home residents may be served in an ALP; since that time, new ALP options such as special needs programs for dementia care and enriched ALP to

allow aging-in-place have been introduced, and 5% may now be too conservative an estimate.

- **Managed Long-Term Care:** For eligible individuals enrolled in a managed long-term care program, Medicaid pays a “per member per month” payment. In return, the program is responsible for meeting all the long-term care needs of the individual, including personal care, nursing services, therapeutic services, medication administration, etc. Only 19 entities are licensed, and program growth has been limited. Some issues identified with the program are:
 - Six of the programs are PACE or Pre-PACE, which is a program that combines both Medicare and Medicaid monthly payments in return for providing all primary, acute, and long-term care. However, PACE regulations are stringent, requiring participants to give up their doctors for program doctors and mandating attendance at Day Centers.
 - New York State negotiates the monthly payment with the licensees, based on the program’s costs and an upper payment limit of the county’s nursing home costs. However, most of the program enrollees are unlikely to be nursing home residents, and so the payment limit may be too generous. (Some States pay a maximum of 50% nursing home costs/50% HCBS costs to mitigate this issue.)

Non-Institutional Care Models: Opportunities and Challenges to Expansion

At least two major questions concern home and community-based care models:

- Does greater availability of such options reduce nursing home utilization, or is there a “woodwork” effect that increases the total number of beneficiaries receiving Medicaid-funded services?
- Are they cost effective compared with nursing facility care?

Evidence available to answer these questions is limited. Some studies seem to indicate that the expansion of non-institutional services does contribute to a modest decline in nursing home utilization. For example, in Michigan, an expansion of waiver services was followed by a 7% drop in nursing home bed-days in three years. A 1996 Lewin Group study found that while Medicaid nursing home spending increased 140% nationwide from 1980-1994, Washington State’s increased by 121%, Colorado’s by 92%, and 69% in Oregon, all three of which were states that expanded non-institutional services.⁷

Because assisted living can take some nursing home candidates, many states are now expanding their Medicaid Assisted Living Programs (ALPs):

Number of Medicaid Waiver Clients in Residential Settings (selected states)⁸			
State	2000	2002	2004
Arizona	1,240	2,300	3,067
Colorado	2,654	3,773	3,804
Florida	1,458	2,681	4,167
Georgia	2,262	2,759	2,851
Minnesota	397	2,895	4,144
New Jersey	699	1,500	2,195
Oregon	2,573	3,600	3,731
Washington	2,919	3,762	7,404

States are attracted to the potential for ALPs to care for persons requiring lower levels of care in less restrictive settings and decrease the utilization of higher-cost nursing facilities. States with Medicaid assisted living reimbursement include: Florida, Georgia, Maine, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, and Wisconsin.

Expansion of Medicaid assisted-living capacity is a complex affair. Issues to consider:

- It is likely to require additional capital investment as few nursing homes can be easily converted to independent living units. To limit capital investment in new ALP beds, the New York Association on Homes and Services for the Aging has proposed the creation of a Medicaid-funded service package for residents of adult homes, enriched housing programs, and licensed assisted living programs. This proposal delineates Medicaid—not SSI—as the payer responsible for all personal care and health-related services, among other provisions.
- Should the “woodwork effect” materialize, it could result in additional total Medicaid spending.
- The diversion of residents from nursing homes could exacerbate the financial stress being experienced by nursing facilities with low occupancy rates.

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¹ Greater New York Hospital Association Health Care Statistics, 2005

² Kaiser Family Foundation, statehealthfacts.org

³ ibid

⁴ New York State Medicaid Quarterly and Annual Reports

⁵ ibid

⁶ Joint Association Task Force on Nursing Home Reimbursement, February 2006, New York Association of Homes and Services for the Aging/New York State Health Facilities Association/Healthcare Association of New York State

⁷ “Has the Medicaid Waiver Reduced Nursing Home Utilization?” A White Paper by the Area Agencies on Aging Association, Michigan

⁸ US Department of Health and Human Services, State Residential and Assisted Living Policy, 2004