LTCCC LONG TERM CARE COMMUNITY COALITION
*Working to improve long term care through research, education & advocacy*

# Modifying the Case-Mix Medicaid Nursing Home System to Encourage Quality, Access and Efficiency

## EXECUTIVE SUMMARY

### Public Funds for Nursing Homes

Nursing homes receive public funding from states in many ways. They are reimbursed for the care they give to Medicaid residents through the Medicaid nursing home reimbursement systems. These systems sometimes include add-ons to the reimbursement rate for hard to place residents or for residents with special needs. In addition, some states have grant programs that give additional Medicaid funds for special projects; some give facilities additional Medicaid funds for performing well ("pay-for-performance" and other incentives to promote quality). Some of these states have begun to move their reimbursement system from one based only on facility costs to one more focused on quality. Given the fiscal crisis that New York State and other states find themselves in and the many care problems still existing in our state's nursing homes, it is crucial that the state undertake a comprehensive assessment of these funding streams. How are funds being granted? Is the state getting quality care for its money? Can the system be modified in a way that all public funds going into nursing homes encourage and ensure access, quality and efficiency? Can the Medicaid reimbursement system be modified to focus on positive resident outcomes rather than simply on facilities' reported costs?

### Case Mix Nursing Home Reimbursement

Case-mix reimbursement has become the most frequently used payment system for Medicaid nursing home care. Many states moved to a case-mix system in order to: (1) improve access to care (for heavy care residents) by varying the reimbursement rate with the resident's condition; (2) improve efficiency and contain costs by paying prospectively; and (3) enhance quality of care by linking reimbursement to the acuity of care.

However, a case-mix system also has a number of inherent disincentives for quality and access: (1) because facilities are paid higher rates for heavier care residents, there is a possibility that lighter care residents, those in the lower paying categories, who still need nursing home care, may not be attractive to nursing homes and will not get the care they need; (2) because residents who improve are reclassified into a lower paying category,

there is a built in disincentive for facilities to help residents improve; and (3) 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.

## Project Goals

This study is focusing on how different states, using a case-mix reimbursement system, encourage access, quality and efficiency. Given the potential negative incentives in case-mix reimbursement systems, a number of states have added creative components to the payment methodology in order to ameliorate their effects and have looked for other ways to use Medicaid funds to give incentives for access, quality and efficiency. By analyzing and evaluating these components, the goals of this project are to make recommendations to:

1. Modify the nursing home case-mix system to better encourage quality care, access and efficiency.
2. Relate nursing home reimbursement to inspection and enforcement systems.
3. Relate nursing home reimbursement to quality outcomes.
4. Respond to the specific New York State budget proposals as the state identifies, assesses and implements ways to modify its reimbursement system, so that it better achieves these goals of quality and efficiency in the face of the current economic crisis.

## Methodology

1. Detailed information was gathered on the characteristics of each of the 34 states using a case-mix nursing home Medicaid reimbursement system similar to New York State. Four main sources were used to collect these data: state statutes and regulations, provider manuals distributed by the states, information gathered from previously published scholarly articles and, in our seven case study states, interviews with state officials.

2. In order to get the perspective of those most directly affected by these issues, online surveys were developed to be sent to ombudsmen and citizen advocacy groups in each of the 34 case-mix states researched. 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.

3. 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. Using a uniform set of questions, state officials responsible for implementing and administering their states' Medicaid reimbursement systems were interviewed by telephone.

4. All of the collected data were analyzed and used as a basis for the individual case studies presented in this final report.

## Findings

### Access Incentives

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. A number of the states that have introduced add-ons to rates or other ways of encouraging facilities to admit certain categories of residents began their initiative when the states identified people who were finding it difficult to gain admission to state nursing homes; others began based upon provider lobbying of their legislatures and governors. It is unclear whether all of these initiatives are needed and whether they have been successful in meeting their goals. Typical add-ons are for: (1) ventilator dependent residents; (2) brain-injured residents; and (3) residents with dementia or Alzheimer's. New York has a number of these, some with programmatic requirements and others without.

### Quality Incentives

In order to encourage quality, states have used Medicaid funds in various ways. A number of states have structured their Medicaid case-mix reimbursement system in ways to encourage spending in direct care (acknowledging that spending in direct care is critical to quality care). They have done this by setting ceilings (caps) higher on direct care expenses than for other expenses, such as in-direct expenses, or they have put caps only on in-direct expenses. Most do not offer efficiency incentives in the direct care areas to encourage spending. Some states even require facilities to spend any savings they have incurred as a result of spending less than the caps or floors on direct care. One state 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. This state also requires documentation that a negative outcome was not the fault of the facility before they reimburse for certain treatments for that outcome. A few of the states are denying efficiency incentives to facilities with deficiencies; one state lowers the rate for facilities

with major care problems. Another state 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. 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). This project is focusing on ways in which states can redirect the reimbursement system from purely a facility cost based system to one which is based more on quality outcomes. Thus, money that is used in these special pools of funding must also be seen as a part of the reimbursement system.

### Efficiency Incentives

States used two basic methods to encourage facilities to operate efficiently.

- The first method sets limits on reimbursement which are tied to either the median or mean costs of all facilities within a state or peer group. There are two ways the states are using this method:
    - Reimbursement is limited to a set rate, regardless of the historical costs of the facility. Thus, a facility is reimbursed at a median or average state-wide or peer group –wide rate.
    - Ceilings and sometimes floors are set on spending as a certain percentage of the median or mean state (or peer group)-wide cost. In such a system, facilities spending above a ceiling or below a floor will receive that ceiling or floor rather than the facility's actual projected cost.
- The second method gives bonuses (efficiency incentives) to facilities who keep their costs below a ceiling.

Some states may be combining elements of both of these methods.

Other methods:

- Some states limit the fraction of the total cost that can be spent on a particular cost center (for example, administrative cost center or other indirect cost center).
- Some states require the facilities to maintain a certain occupancy level.
- Some states give bonuses for making changes to a facility that will make it more efficient such as energy conservation renovations.

## 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.

### Specific Recommendations for New York State - New York should:

- Set specific goals for the proposed add-ons for residents with dementia and bariatric needs and for the special rates for residents with special needs such as traumatic brain injury, AIDS, neurobehavioral and ventilator dependency. What does the state want to accomplish?
- Develop goals related to programmatic requirements and positive resident outcomes.
- Require facilities to meet these goals within certain parameters.
- Require those facilities who do not meet these goals to develop a plan, approved by the state, as to how they will meet these goals or exclude them from receiving the add-ons or special rates.
- Set up a formal mechanism to evaluate whether the add-ons and special rates have met these goals.
- Dedicate resources to make sure that the evaluations are carried out for the duration of the incentives.

## Quality

- States should encourage spending in direct care.
- Links must be made to 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 costs 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.

### Specific Recommendations for New York State

- If the Governor's proposal to move to a regional rate goes into effect, a system must be in place to monitor the effect on quality care focused specifically on this change. Has quality diminished in facilities that will be receiving less money? What is happening to quality in those facilities receiving more money?
- New York should develop initiatives to both encourage spending in the direct care areas while linking the additional funding to its inspection and enforcement systems. The state could consider requiring facility spending in specific deficient areas found. For example, if a facility is found to be deficient in dietary on its inspection, the state could consider mandating
  expenditures in that area. It should also consider putting additional caps on those in-direct costs less related to care to offset additional expenditures in direct care.
- New York should add a number of other criteria to its proposal for quality pools such as resident and employee satisfaction that would be measured by an independent third party, and staff retention/turnover.
- New York should consider limiting the use of temporary agency staff in its measurement of staffing levels.
- New York should develop a system, with a source of funding, for ongoing evaluation of these initiatives to find out if it is successful.
- New York State and other States should consider ways to directly tie reimbursement to quality by tying the rates to quality or improvement in quality by beginning to calculate part of the rate based upon quality outcomes.
- New York should move more and more of the Medicaid reimbursement funds into the quality pools over time.

### 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 and
    - 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 using a single statewide or peer group wide rate for facilities should consider using ceilings and floors for direct care costs.
- States should encourage spending in direct care areas by not permitting efficiency payments in their direct care cost component.
- Efficiency payments should be considered in those non direct care areas not related to care or quality of life.
- 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 are not disproportionate to the amount being spent in direct care.
- 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?

## Specific Recommendations for New York State

- Keep ceilings and floors for the direct care costs to permit more spending in direct care.
- Require facilities spending below the floor in direct care to spend all or part of the difference between the floor and their costs on direct care or return the funds to the state. Without this requirement low spending facilities would have no incentive to spend more on their residents and would in effect be receiving a greater profit for providing less care.
- Use regional rates for those indirect costs less related to care such as administrative costs.
- Require the facilities who will be major "winners" when this new methodology goes into effect (those receiving the difference between their costs and the average) to spend a portion or all of their additional funds in direct care or return the funds to the state. Especially at this time of fiscal crisis, the state should not give a windfall to facilities without getting something back for nursing home residents.
- Require that facilities receiving transition funds because they are "losers" in the new system have a plan, approved by DOH, which demonstrates how the facility will use the funds to maintain access, quality and efficiency in the new system in order to receive the funds.
- Consider what costs it can put limits on in relation to total costs. It should look specifically at administrative costs and other areas that do not directly affect residents.
- Develop methods of rewarding facilities that develop energy efficient or "green improvements" to their facilities.
- Develop a process to closely monitor and evaluate the effect of this change on resident care and quality of life and the financial viability of facilities.
- Move more and more of the Medicaid reimbursement funds into the quality pools.