



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

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# **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 indirect 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.

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

## INTRODUCTION

### **Public Funds for Nursing Homes**

Nursing homes receive public funding in many ways. They are reimbursed for the care they give to Medicare and Medicaid residents through the Medicare and 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). 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’ costs?

### **Nursing Home Medicaid Reimbursement**

When states set up their nursing home Medicaid reimbursement systems, they must make a number of decisions concerning access, quality and efficiency. Among these are:

- Whether to use a retrospective system (i.e., facilities are reimbursed after giving care based upon their actual costs), a prospective system such as case-mix (i.e., facilities are given a rate before they give care based upon their projected costs) or a combination of both.
- Whether to use a system where reimbursement is limited to a set rate, regardless of the historical costs of the facility or whether to set ceilings and floors on spending as a certain percentage of the median or mean state (or peer group)-wide cost).
- Whether to group facilities into peer groups for calculating rates based upon common characteristics such as geographical location, size, etc.
- Whether to set limits on reimbursement for certain expenses such as administrative costs.
- Whether efficiency bonuses will be used.
- Whether to direct higher payment to certain areas such as direct care.

- How to encourage quality performance.
- How to encourage access of hard-to-place residents and residents with special needs.

### **Case Mix Nursing Home Reimbursement**

Case-mix reimbursement has become the most frequently used payment system for Medicaid nursing home care. In addition to the Federal Government using it for Medicare reimbursement to nursing homes, 34 states in addition to New York State now use it for reimbursing facilities. In case-mix reimbursement, 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). The system consists of two parts: a case-mix classification and a payment methodology. Classification involves the assessment of residents to estimate the amount of care they will need and placement into a category or group with other residents based upon similar care needs. Each group is given a “case mix index (CMI)” which represents, relatively, the resources consumed by the average resident in each group. The CMI is used in the payment methodology. The payment methodology, or how the specific rate is calculated, varies state by state although as a rule the higher the CMI, the higher the rate.

Many states moved to a case-mix system in order to:

- Improve access to care (for heavy care residents) by varying the reimbursement rate with the resident’s condition.
- Improve efficiency and contain costs by paying prospectively.
- Enhance quality of care by linking reimbursement to the acuity of care.<sup>1</sup>

The expectation is that a reimbursement policy that is responsive to differences in resident care needs will improve fairness among nursing homes by paying more to facilities whose higher costs are a result of having heavier-care residents and, by paying prospectively states hope that facilities can become more efficient by trying to spend at or below the prospective rate.<sup>2</sup>

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<sup>1</sup> Bjorkgren, M.A. and Fries, B.E., International Journal of Healthcare Technology and Management, “Applying RUG-III for Reimbursement of Nursing Facility Care”, Volume 7, Number 1-2/2006, pages 82-99.

<sup>2</sup> Davis, M.A., Freeman, J.W. and Kirby, E.C., Health Services Research, “Nursing Home Performance under Case-Mix Reimbursement: Responding to Heavy-Care Incentives and Market Changes,” September 4, 1997.

However, a case-mix system also has a number of inherent disincentives for quality and access:

- 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.
- 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.

In fact, a number of studies have indicated that although the goal of encouraging access for heavier care residents has been accomplished, other goals have not been met. For example, several studies found a decline in professional (registered nurse [RN] and licensed practical nurse [LPN]) staffing after Medicaid case mix<sup>3</sup> and Medicare Case-Mix<sup>4</sup> implementation, although concurrent nursing shortages in some markets may make it difficult to attribute this solely to case mix reimbursement.<sup>5</sup> The studies of Medicare case mix found that higher proportions of Medicare residents were associated with lower staffing levels. In addition, studies found that there was a worsening of certain quality indicators for long-stay residents which has been attributed to a reduction in observation and preventive care, consistent with the reduction in professional staffing under Medicare case-mix.<sup>6</sup> Other studies have found no increase in nurse staffing based upon the increased

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<sup>3</sup> Grabowski, D. C. (2002). *Inquiry*. "The Economic Implications of Case mix Medicaid Reimbursement for Nursing Home Care," 39, 258–271.

<sup>4</sup> Konetzka, R. T., Yi, D., Norton, E. C., & Kilpatrick, K. E. (2004). Effects of Medicare payment changes on nursing home staffing and deficiencies. *Health Services Research*, 39, 463–488 and White, C. F. (2005). Medicare's Prospective Payment System for skilled nursing facilities: Effects on staffing and quality of care. *Inquiry*, 42, 351–363.

<sup>5</sup> The issue of staff shortage is complex. One of the causes of staff shortages is poor working conditions in nursing homes. See Kaiseredu.org, Addressing the Nursing Shortage: Background Brief, July 2008: "...research suggests that the current shortage is the product of several trends including: steep population growth in several states, a diminishing pipeline of new students to nursing, a decline in RN earnings relative to other career options, an aging nursing workforce, *low job satisfaction and poor working conditions* that contribute to high workforce attrition rates, and an aging population that will require intense health care services." Thus, at least some of shortage could be diminished if conditions in nursing homes improved.

<sup>6</sup> Konetzka, R. T., Norton, E. C., Sloane, P. D., Kilpatrick, K. E., & Stearns, S. C. (2006). Medicare prospective payment and quality of care for long stay nursing facility residents. *Medical Care*, 44, 270–276.

care needs after Medicaid case mix reimbursement adoption.<sup>7</sup> Also a decrease in rehabilitation services attributed to a decline in physical therapy staff was found in two studies.<sup>8</sup>

### **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 they better achieves these goals of quality and efficiency in the face of the current economic crisis.

### **Methodology**

1. An advisory committee, consisting of representatives of consumer organizations, providers and researchers, was formed to provide guidance for the project.<sup>9</sup>
2. Using information from research and conversations with a number of prominent researchers, thirty-four states (in addition to New York) were identified as using a case-mix reimbursement system for their Medicaid nursing home reimbursement systems.

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<sup>7</sup> Butler, P. A., & Schlenker, R. E. (1989). Case mix reimbursement for nursing homes: Objectives and achievements. *Milbank Quarterly*, 67, 1031–1036.

Cohen, J., & Dubay, L. (1990). The effects of Medicaid reimbursement and ownership on nursing home costs, case mix and staffing. *Inquiry*, 27, 183–200.

<sup>8</sup> White C. F. (2003). Rehabilitation therapy in skilled nursing facilities: Effects of Medicare's new prospective payment system. *Health Affairs*, 22, 214–223. Woodchis, W. P. (2004). Physical rehabilitation following Medicare prospective payment for skilled nursing facilities. *Health Services Research*, 39, 1299–1318.

<sup>9</sup> See Appendix for a list of participants.

3. Detailed information was gathered on the characteristics of each of these states' nursing home Medicaid reimbursement systems. A number of different data were collected: details of the resident classification systems; the number and characteristics of cost centers; the mechanism used to calculate rates; whether the system was resident or facility specific; the use of ceilings or floors; frequency of rebasing; peer groupings; the number of nursing facilities and residents in each state; and all incentives for access, efficiency and quality care. 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.<sup>10</sup>
4. After analyzing the data collected, a determination was made to focus on the areas most relevant to the goals of this project for further data collection and analysis.
5. To facilitate analysis and comparison of state systems the data were organized on a chart (included in appendix).
6. 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.
7. 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.
8. State officials responsible for implementing and administering their states' Medicaid reimbursement systems were contacted and phone interviews were scheduled.
9. Interview questions were developed for each state. Each interview lasted between thirty minutes to an hour 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

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<sup>10</sup> For a full list of references see Appendix.

their initiatives, whether state officials felt they were successful, and if they would change any aspects of their system.

10. After the initial interviews, all the data collected were analyzed and several follow up phone interviews were scheduled to address any remaining questions on each state's reimbursement system.
11. Follow up questions were written and a second round of interviews with a few of the state officials were conducted.
12. 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.
13. All of the collected data were analyzed and used as a basis for the individual case studies presented in this final report.



## FINDINGS

This is a summary of all the findings on all states using case-mix reimbursement for their nursing home Medicaid reimbursement system.<sup>11</sup> For more in-depth information, please see detailed chart in the appendix.<sup>12</sup> The number of facilities in the 34 states other than New York using case-mix ranged from a high of 1,149 (Texas) to a low of 38 (Vermont); the number of residents from a high of 89,698 (Texas) to a low of 2,981 (Vermont); and the percent of their residents covered by Medicaid ranged from a high of 77 (Mississippi) to a low of 48 (Iowa). New York State has 638 facilities serving 108,749 residents, of which 72 percent are on Medicaid.

### 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.<sup>13</sup> 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.

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<sup>11</sup> 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. This information is accurate to the best of our ability.

<sup>12</sup> For a copy of the full report and related materials, see [www.nursinghome411.org](http://www.nursinghome411.org).

<sup>13</sup> Information on how these access needs were identified and whether the initiatives have been evaluated was gathered on interviews with officials in the case-study states or by researching any studies conducted on these indicatives. If the information below does not state this information, it means that the information was not available.

Below is a summary of actions taken by the different states. States marked with \* are case-study states. See individual case studies for more detail.

### Delaware<sup>14</sup>

Delaware gives add-ons to facility rates for:

- The care of residents receiving an active rehabilitative/preventative care program. The facility must present individual care plans.
- The care of residents exhibiting disruptive psychosocial behaviors for additional nursing staff intervention and for psychosocial/preventative care programs. The facility must present documentation of behaviors and care plans.

### Georgia\*

- Georgia gives facilities a rate adjustment for residents with moderate to severe cognitive impairment. The state had identified the admitting of these residents as a problem. There are no programmatic requirements for this add-on. Facilities receive the add-on if they admit such residents.

### Idaho

Idaho gives facilities an add-on to their rates for:

- Residents with special behavioral symptoms and for traumatic brain injury units.
- Ventilator dependent residents.
- Residents not residing in a special care unit needing one-to-one staffing.

### Illinois

- A number of add-ons for (51), among others, restorative care (i.e. bed mobility, walking, dressing etc); bladder retraining; psychotropic medication monitoring; dementia care unit; ventilator care; morbid obesity; pressure ulcer management; pain management and restraint-free care. In order to receive these add-ons, providers must document care.

### Indiana

Indiana gives facilities an add-on to their rates for:

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<sup>14</sup> Based upon November 18, 2009 draft form.

- Special behavioral and traumatic brain injury units.
- Ventilator dependent residents.

### **Kansas\***

- 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.

### **Kentucky**

Kentucky gives facilities an add-on to their rates for:

- Special behavioral and traumatic brain injury units.
- Ventilator dependent residents.

### **Maine**

- Maine gives add-ons for rehabilitative services for brain-injured residents. In order to receive the higher rates, the facility must meet a number of requirements related to staffing and physical design.

### **Maryland\***

- 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.

### **Massachusetts**

Massachusetts gives an add-on for:

- Facilities that have over 75 percent of their residents with multiple sclerosis.
- Residents with mental retardation and developmental disabilities in a facility that maintains clinical and administrative procedures.

### **Mississippi\***

- 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.

### Nebraska

- Nebraska provides an incentive to city or county owned nursing homes to encourage them to take Medicaid residents.
- Nebraska provides special rates for ventilator dependent residents, residents with brain injuries, etc, but only if facilities demonstrate they have appropriately trained staff, have a distinct unit and have specific admission and discharge criteria.

### New Hampshire

New Hampshire gives add-ons for:

- Residents who are brain injured.
- Ventilator dependent residents.

### New York State

- Currently New York State gives facilities higher rates for Special Care units for people with AIDS, traumatic brain injury, ventilator dependency, pediatric care needs and neuro-behavioral care needs. These higher rates have significant programmatic requirements. In addition, there is an add-on to the rates for residents with dementia who fall into the lower RUGs categories.<sup>15</sup> In 2006 legislation was passed to create additional add-ons for dementia residents in the lower RUGs categories and for bariatric residents. This has not gone into effect (as of March 2009).
- In 2008 the Governor proposed in his executive budget for 2009-2010 the add-ons for dementia residents (without any programmatic requirements) and bariatric (without any programmatic requirements at this time). In addition, he proposed a reduction in payment for residents with lower acuity needs to encourage nursing homes to find less restrictive settings for these residents who may be inappropriately placed in the facility.<sup>16</sup>

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<sup>15</sup> There are few requirements attached to this and little oversight, if any, of the few that are in regulation.

<sup>16</sup> While this goal is an important one, if this initiative goes into effect, close monitoring must be undertaken to make sure that people who need or want nursing home care do not “fall between the cracks” and find they

## **North Carolina**

North Carolina gives facilities a specialized rate for:

- Ventilator dependent residents.
- Residents needing intensive head injury rehabilitation.

## **North Dakota**

North Dakota gives facilities an add-on for:

- Ventilator dependent residents.
- Residents with total parenteral nutrition.

## **Ohio**

Ohio gives add-ons for:

- Residents who are brain injured.
- Ventilator dependent residents.
- Residents with end-stage Alzheimer's disease.
- Residents with AIDS.

## **Oregon**

- Oregon has add-ons for complex medical needs of residents. This has programmatic requirements for the care of such residents.

## **Pennsylvania**

- Pennsylvania gives an incentive payment to facilities with more than 80 percent Medicaid residents.

## **South Dakota**

South Dakota gives an add-on for:

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cannot get care because there is no alternative for them to the nursing home and the nursing home may no longer want to admit them.

- Rental cost of ventilator equipment for dependent residents.
- Rental of pressure reduction mattresses or low air loss beds (up to \$25 a day).

### Texas\*

- 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.

### Utah\*

- Utah gives providers an add-on if they admit “behaviorally complex” residents. The add-on is approved if an assessment of the acuity and needs of the resident demonstrates that the facility is not adequately reimbursed by the RUGS score for that resident.

### Vermont

- Vermont gives an add-on for residents who have unique physical conditions which make it more difficult to provide care. The add-on must be approved by the state.

### Virginia

Virginia gives add-ons for:

- Residents who are brain injured.
- Beds for the treatment of residents with at least a stage IV ulcer.

### Washington

- Washington can give an add-on to the direct care rate for residents who have unmet exceptional care needs if it approves a facility’s plan.

## 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 expense, or they have put caps only on in-direct expenses. Most do not offer efficiency incentives (see next section on efficiency) in the direct care areas to encourage spending. Some states even require facilities to spend any savings they made by 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 treatment. A few of the states are denying efficiency incentives (see the next section) 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. This initiative is in current state law but will not be enacted for a number of years. 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.

Based on our collected information, below is a summary of all quality incentives used by each state:

### Delaware

- In order to discourage the use of agency staff, Delaware has a cap on reimbursement for agency nurse costs.

### Georgia\*

- 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:

- Performance in clinical areas such as: (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; and
- Performance in non-clinical areas such as (1) staff retention; and (2) use of resident satisfaction surveys.

Facilities identified as a Special Focus Facility by CMS will not earn a quality incentive unless certain conditions are met (Note: Special focus facilities are nursing homes that have been identified as having long term, serious problems requiring special and intense oversight).

- Georgia also has a special initiative giving facilities add-ons to their rates if their staffing hours are at least 2.5 hours per resident per day in order to encourage higher staffing (it is important to note that this is well below both the national average and good professional standards).

### Idaho

- Idaho has funds to award a quality incentive to facilities recognized for providing quality care.

### Illinois

- A number of add-ons for (51), among others, restorative care (i.e. bed mobility, walking, dressing etc); bladder retraining; psychotropic medication monitoring; dementia care unit; ventilator care; morbid obesity; pressure ulcer management; pain management and restraint-free care. In order to receive these add-ons, providers must document care.

### Indiana

- Indiana will increase reimbursement based upon facility performance on a nursing home report card developed by the Indiana Department of Health.



## Iowa

- 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.

The resident advocacy committee is a requirement of all Iowa facilities. Committee members represent and advocate for the rights of residents in each facility. The members investigate complaints and grievances. This is unique to Iowa.

## Kansas\*

- The Nursing Facility Quality and Efficiency Incentive factor in Kansas is a per diem add-on ranging from zero to three dollars. It combines quality and efficiency incentives. The incentive factor is determined by points using the following outcome measures:
  - Case-mix adjusted nurse staffing ratio.
  - Operating expense.
  - Staff turnover.
  - Staff retention.
  - Occupancy (total and Medicaid).
  - Survey findings.

While Kansas also bases its criteria on state averages, it requires facilities to have at least 110 percent of the statewide staffing median or 4.05 hours of direct nursing care per day per resident in order to receive points towards for the incentive factor. A little over four hours is considered a good professional standard. Kansas tries to discourage the use of contract or agency staff by limiting their use in this measure.

- Kansas encourages spending in direct care by administering a wage pass-through program for direct care workers.

- Kansas has a higher ceiling set for Direct Care costs than for Indirect or Operating Costs.

### Louisiana

- 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 gives an add-on for facilities that convert a semi-private room to a private room for use by a Medicaid resident.
- Louisiana has a higher ceiling set for Direct Care costs than for other cost centers.

### Maine

- Facilities not meeting minimum staffing ratios have their base year direct cost component increased.
- For the Routine cost component only, facilities that spend less than their prospective rate may retain any savings as long as it is used to cover direct care costs.
- 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.
- A cap is placed on administrative costs.

### Maryland\*

- Maryland encourages quality care for residents needing special licensed nursing care by giving facilities add-ons to their rates only if they document and carry out extensive programmatic requirements with licensed personnel.
- In order to ameliorate the potential negative incentive in case-mix reimbursement not to get residents better, Maryland has instituted a rule that if a resident's condition improves so that he/she is classified in a lower paying group and the resident has been in the higher group for at least two months, reimbursement will continue at the higher level for two more months.
- Maryland uses CMP funds (civil money penalties, fines from poorly performing nursing homes) to fund a grant program to improve quality.

- 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.

### Massachusetts

- This state gives facilities an add-on if they score high on a performance tool.

### Minnesota\*

- 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.
- Minnesota adds and changes criteria each year, depending upon its experiences.
- Facilities earn “stars” based upon how much above the state median they are on the criteria.
- Resident satisfaction and quality of life interviews are conducted in all nursing facilities on an annual basis. Using a standardized interview, trained interviewers employed by an independent contractor of the state interview a sample of residents in each facility. The interview measures: comfort, environmental adaptations, privacy, dignity, meaningful activity, food enjoyment, autonomy, individuality, security, relationships and mood.
- Minnesota also awards payments for quality and efficiency with a pool of money on a competitive basis.
- Minnesota will be tying reimbursement rates directly to quality in the near future. Current state law requires the state to determine limits on cost categories based on quality scores. The higher the facility’s score, the higher the cost limit. Under the law, this initiative will go into effect once rebasing is phased in.

### Mississippi\*

- Mississippi attempted to encourage spending in direct care by requiring facilities that received the floor cost to increase their spending in this area or return the money to the state (in 1994-1995).

## Montana

- Montana adds to the provider rates to increase direct worker wages.

## Nebraska

- Nebraska's ceiling on direct care is higher than for the other cost centers.

## New Hampshire

- Only New Hampshire's Patient Care cost center has a ceiling; all other centers, except capital, are paid a flat rate based on statewide averages.

## New Jersey

- 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.

## New York State

- The Governor has proposed for his 2009 to 2010 budget the following initiatives to encourage quality.
  - "Nursing home quality pools," will award funds to facilities who are in the top 20 percent on the following criteria:
    - Inspection findings.
    - Staffing levels (including contract staff) with RN numbers more heavily weighted than other staff.
    - Quality indicators
      - Insertion of catheters left in place.
      - Urinary tract infections.
      - Increase in need for help with daily activities.
      - Decrease in ability to move about room.
  - A loan repayment program and scholarship fund to help recruit more nurses.

## North Carolina

- North Carolina has add-ons for dietary costs related to religious needs.
- North Carolina's ceiling on direct care is higher than for the other cost centers.

### Ohio

Ohio has a combination of a quality and efficiency incentive. The criteria are:

- 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.

### Pennsylvania

- Pennsylvania gives a durable medical equipment grant to facilities to enhance the quality of life.
- Pennsylvania caps administrative costs.
- Pennsylvania's ceiling on direct care is higher than the other areas..

### South Carolina

- 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

- 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.
- South Dakota's ceiling on direct care is higher than for the other cost centers

### Texas\*

- Texas' enhanced staffing program is different from a few of the other states that encourage higher staffing levels in that Texas' staffing program permits facilities to staff their facilities above the state average and/or compensate their workers above state averages.
- Texas also offers an add-on for compliance with state and federal regulations and performance on quality indicators.
- Texas' ceiling on direct care is higher than the other areas.

### Utah\*

- 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.

Facilities cannot have had any violations that are at an "immediate jeopardy" level at the most recent survey or during the incentive period. Facilities have to give examples of how they have assessed and measured their plan and what improvements have been made.

- Utah also has a fund of money to target certain areas for a one time add-on. Each year the state changes the area. For 2009, facilities that install enhanced nurse systems, purchase at least one new patient lift system, and/or purchase a new side entry bath will receive the add-on.

### Vermont

Vermont's quality initiative includes efficiency criteria and safety criteria as well as quality criteria. Vermont's criteria include:

- Number and level of deficiencies.
- No complaints on most recent survey related to quality of life or care.
- Resident satisfaction.
- Fire safety.
- Efficient running of the facility.

## Washington

- Washington's ceiling on direct care costs is higher than for indirect.

### 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. This creates an incentive for facilities to keep their costs at or below the median in order to avoid an operating loss or make a profit. This in turn will lower the median or mean costs of all facilities in future years.
  - 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. This encourages facilities to keep their costs below the well defined limits in order not to incur a loss (by going above the ceiling) or to make a profit (by staying below the floor). Using ceilings permit facility costs to vary more widely than just using averages or medians as a 'cap.' Thus, using ceilings permits facilities to spend more than the average or median and may encourage facilities to spend more. The use of floors may encourage facilities to spend less than the average or median.
- The second method gives bonuses (efficiency incentives) to facilities who keep their costs below a ceiling.
  - Generally, states using this method give facilities a percentage of the difference between the ceiling and the projected cost for the various cost centers.
  - Most of these states 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 doing so could in turn reduce quality of care to residents). As shown

above in the Access and Quality Incentive sections, some states have incentives to actually encourage spending on direct care.

- 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. 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.

Below is a summary of actions taken by the different states.

### Arizona

- Arizona reimburses the indirect and capital portion of the rate at a single statewide rate.

### Colorado

- Colorado gives an efficiency incentive only in the Administrative, Property and Room and Board cost centers.
- Facilities receive this incentive if their projected cost is less than the ceiling cost.

### Delaware

- 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.
- Delaware has set a 90 percent occupancy level for the calculation of rates.

### Georgia \*



- 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.

### **Idaho**

- Idaho gives an efficiency allowance in the Indirect cost center only to facilities whose projected indirect costs are less than the ceiling. This incentive subject to fund availability.

### **Iowa**

- Iowa gives an efficiency incentive in the indirect care cost centers only if a facility's indirect costs are below the state median.

### **Kansas\***

- The Nursing Facility Quality and Efficiency Incentive Factor (see above in quality incentives section) is a per diem add-on ranging from zero to three dollars. It is designed to encourage both quality care and efficiency.
- Kansas uses ceilings for all costs.

### **Kentucky**

- Kentucky reimburses facilities at a statewide median rate.

### **Louisiana**

- Facilities are reimbursed at a percentage of the statewide median rate for direct care and administrative and operating expenses.

### **Maine**

- Maine places a ceiling on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation, thus encouraging more efficiency in these areas.

- Maine permits depreciation for a number of energy efficient improvements such as: insulation, energy efficient windows or doors, shades and shutters, caulking and weather stripping.

### **Maryland\***

- The state gives an efficiency incentive in the Administrative and Routine cost center and the Other Patient Care cost center. It does not offer the incentive in the Nursing Service cost center.
- Facilities receive a percent of the difference between the ceiling and the projected cost in the Administrative and Routine Cost center to a maximum of 10 percent of the ceiling cost.
- For the Other Patient Care cost center facilities receive a percent of the difference between the ceiling and the projected cost up to a maximum of 5 percent of the ceiling cost.

### **Massachusetts**

- Massachusetts gives a flat rate for the Other Operating costs and Nursing costs centers are calculated by using a statewide flat rate for each of the resident groups.

### **Minnesota\***

- Minnesota gives an efficiency incentive in all the cost centers except the direct care cost center.
- The incentive amount is a percent of the difference (up to a maximum) between the cost and the ceiling for the indirect care cost centers.
- The state also 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.

### **Mississippi \***

- Mississippi gives an efficiency incentive in the Administrative and Operating cost center.

- If the facility's cost falls below the ceiling, then its administrative and operating rate is its trended cost plus 75 percent of the difference between the greater of the trended cost or the median and the ceiling.
- Mississippi has set the minimum occupancy level at 80 percent for rate calculation as the state deems it to be the most efficient.

### Montana

- Montana sets Operating costs as 80 percent of statewide price for nursing facility services.
- Montana sets Direct care costs as 20 percent of the statewide price for nursing facility services, adjusted for acuity.

### Nebraska

- Nebraska sets a ceiling on Direct Nursing care cost as a percent of the median peer group cost.

### Nevada

- Nevada reimburses facilities at a statewide median rate.

### New Hampshire

- New Hampshire applies a ceiling to therapy costs in the Patient Care cost center using the 85<sup>th</sup> percentile of the statewide therapy costs.
- New Hampshire uses a ceiling in the Patient Care and Capital cost center.
- New Hampshire uses statewide medians for the other cost centers except for Capital.

### New York State

- New York State currently uses both ceilings and floors. Its ceilings are the same for all cost centers. Its floors are lower for direct care costs.
- The Governor has proposed in his executive budget for 2009-2010 a major change:
  - Removal of the ceilings and floors.
  - Paying facilities a regional median rate.

- Reducing bed hold payments to 75 percent of the Medicaid rate.

### North Carolina

- North Carolina gives an efficiency incentive in the Direct Care Case-mix Adjusted cost center by giving a percent of the difference between costs and a ceiling.
- North Carolina uses ceilings for the Direct Care Non Case-Mix Adjusted cost center and the Indirect Care Cost Center.

### North Dakota

- North Dakota sets the Indirect Cost Center at the statewide median. All other cost centers are set at a specific per diem dollar amount rather than as a percent of median.

### Oregon

- In Oregon, all allowable costs are arrayed and the basic rate is set at the 63<sup>rd</sup> percentile.

### Pennsylvania

- The state has placed a cap on the administrative costs at 12 percent of total facility costs.
- Pennsylvania sets ceilings as a percent of the median costs within a peer group.

### South Carolina

- South Carolina gives an efficiency incentive in three cost centers: General Services; Dietary; and Laundry, Maintenance & Housekeeping.
- A facility is eligible for this incentive if its actual costs are below the sum of these three cost ceilings.
- The state has set the occupancy level at 96 percent for rate calculation.
- Profit in the cost center of Administration and Medical Records and Services is allowed if the provider's allowable costs are lower than the ceiling.

## South Dakota

- South Dakota uses two levels of ceilings in the Direct Care and In-Direct Costs centers which are each set as a percent of the statewide median costs.
- The first ceiling pays up to 100 percent of costs; all costs up to a second ceiling are paid at 80 percent of costs.

## Texas\*

- Facilities are paid at the statewide median or mean, depending on the cost center.

## Utah\*

- Utah reimburses operating costs at a flat rate.

## Vermont

- The state has set the minimum occupancy level for facilities (except those with 20 or fewer beds) at 90 percent when calculating the rate for Nursing Care and Ancillary cost centers.
- The state gives an adjustment for costs related to installation of energy conservation devices or other efficiency measures.
- Nursing Care and Resident Care cost centers have ceilings sets as a percent of the statewide median.

## Washington

- The state gives an add-on for capital improvements for all new or replacement building construction or major renovation projects.
- Washington uses a minimum occupancy rate for all cost centers except Direct Care to set rates
- Washington uses ceilings in all cost centers as a percent of the median costs in peer groups.

## West Virginia

- West Virginia uses a minimum occupancy level of 90 percent while calculating allowable costs per patient day.
- The state gives an efficiency incentive to facilities whose projected Standard Services costs are less than the ceiling up to a maximum daily amount.
- A facility may be denied the efficiency incentive if they have any deficiencies during the reporting period.
- The state uses ceilings for individual subcomponents of the Standard Services Cost Center by finding the average peer group cost for facilities and then adding the averages together.
- The state uses ceilings for individual subcomponents of the Mandated Services cost center by finding the average peer group cost for facilities and setting costs in the 90<sup>th</sup> percentile as the ceiling.

One major issue arises for all of the incentives: are they being evaluated on a regular basis to make sure that they are meeting the goals for which they were originally intended?

## CASE STUDIES

### GEORGIA

Georgia has 346 nursing homes with 33,982 residents of which 74 percent are on Medicaid. The state uses the RUGs III-34 group model, is cost-based and rebased annually. The state uses five cost centers: Routine and Special Services, Dietary, Laundry and Housekeeping, Operation and Maintenance of Plant, Administrative and General and Property and Related.

#### Access Incentives

Georgia gives facilities a rate adjustment for admitting residents with moderate to severe cognitive impairment. This initiative was developed to encourage facilities to accept these residents who were being turned away from nursing homes. 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. The state has not evaluated whether this initiative has met its goal of increasing access for those with cognitive impairment.

#### Quality Incentives

##### Improving Quality

Facilities are given a one percent add-on to the rate for the Routine and Special Services cost component or center. To qualify for such a rate adjustment, a facility must obtain a minimum of three points based upon a number of different criteria:

- One point must come from performing above state averages in the following clinical areas.
  - Percent of High Risk Long-Stay Residents Who Have Pressure Sores.
  - Percent of Long-Stay Residents Who Were Physically Restrained.
  - Percent of Long-Stay Residents Who Have Moderate to Severe Pain.
  - Percent of Short-Stay Residents Who Had Moderate to Severe Pain.

- One point must come from the non-clinical area – staff retention and use of resident satisfaction surveys. The state has contracted with My InnerView<sup>17</sup> for the non-clinical section. According to state staff, facilities must demonstrate that they participated in the uniform resident satisfaction survey process through My InnerView.
  - Facilities report quarterly averages for staff retention.
- The third point can come from either the clinical or non-clinical.

Facilities placed on the Special Focus Facility list generated by CMS will not earn a quality incentive unless the following conditions have been met:

- The facility's next standard survey and/or compliant survey , after being placed on the list, does not have a deficiency cited over Level E scope and severity; and
- The facility's second standard survey and /or compliant survey , after being placed on the list, does not have a deficiency cited over Level E scope and severity; or
- If the facility is removed from the special focus list by CMS for any other reason.

Interviewed state staff indicated that this initiative has been very successful in the short time it has been in effect (April 2007 was the start date). They believe that there has been a decrease in the use of restraints, pressure sores and residents in pain. Because of this, the state average threshold has gone up and facilities must continue to do better to qualify. In addition, providers seem to want to qualify; the percent of facilities applying has gone from 50 percent to 82 percent. State staff is considering creating a new level of enhancement: 2 percent with additional criteria that will include the requirement that resident satisfaction surveys demonstrate that residents are satisfied. The one caveat raised was that the fiscal problems of the state may necessitate the removal of this initiative.

### **Increasing staffing numbers/staff compensation**

Georgia has an initiative (begun in 2003) to encourage more staff in nursing homes by giving facilities an add-on to their rate. In order to qualify for a 1 percent add-on, a facility must average at least 2.50 nursing hours per resident per day which is the minimum state staffing standard. However, since the national average is 3.5 and studies have indicated

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<sup>17</sup> My InnerView is a company that provides research and collects data to drive performance improvement and business outcomes. My InnerView releases the annual *National Survey of Consumer and Workforce Satisfaction in Nursing Homes* which is based on a dataset about resident, family and employees satisfaction in nursing homes.



that an average of approximately 4.1 hours is needed to provide adequate care and quality of life, while 3 hours is the threshold below which residents are at a high risk for harm, it is important to note that this initiative is in fact awarding facilities for staffing levels that are sub par on several important indicia. State staff believes this initiative has begun to address staff retention, but have not formally evaluated the incentive.

### **Efficiency Incentive**

Georgia uses ceilings and permits a facility to earn 75 percent of the difference between the ceiling and its projected costs in all cost centers (including direct care), subject to a maximum per diem amount.

## KANSAS

Kansas has 331 nursing homes with 18,588 residents of which 53 percent are on Medicaid. Kansas uses the RUGs III-34 group model and is cost based. The state uses three cost centers: Direct Care, Indirect Care and Operating.

### Access Incentive

The state was paying upwards of \$1,000 a day for ventilator-dependent residents who were in out-of-state facilities or who were in hospitals where they no longer needed acute rehabilitation. In order to encourage both access for these residents and to lower Medicaid costs, the state initiated an add-on for ventilator-dependent residents. State staff believes that this initiative has provided access and addressed the fiscal concerns. At least one resident was able to move back to Kansas from an out-of-state facility and currently there are 16 individuals enrolled in the program. There is now one facility in the state that admits these residents. The facility must develop a care plan for each ventilator-dependent resident which is subject to outside review. The one unanticipated consequence has been that the caseload for this program has grown more quickly than the state thought. In fact, according to state staff, several residents from a nearby state moved to Kansas to access this service. However, according to a response to a follow-up survey, a representative of consumers in the state believes that this initiative has not been successful because there is still only one facility in all of Kansas that will take residents who are dependent on ventilators.

### Quality and Efficiency Incentives

The Nursing Facility Quality and Efficiency Incentive Factor was implemented in 2002. It is designed to encourage quality care and efficiency. The incentive factor is a per diem add-on ranging from zero to three dollars. It combines quality and efficiency incentives. The incentive factor is determined by points using the following outcome measures:

- Case-mix adjusted nurse staffing ratio.
- Operating expense.
- Staff turnover.
- Staff retention.
- Occupancy (Total and Medicaid).
- Survey findings.

### **Case-Mix Adjusted Nurse Staffing Ratio**

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. The ratio is based on the hours reported for RNs, LPNs, licensed mental health technicians, medication aides, nursing aides, restorative and rehabilitation aides and contract nursing. Facilities will receive two points if their case-mix adjusted staffing ratio equals or exceeds 4.42, which is 120 percent of the statewide median of 3.68. They will receive one point if the ratio is less than 120 percent of the median but greater than or equal to 4.05, which is 110 percent of the statewide median. Providers with staffing ratios below 110 percent of the median will receive no points for this incentive measure. According to state staff, eligibility for this incentive goes up each year as more and more facilities vie for the reward and the median staffing ratio rises. While Kansas does base its criteria on state medians, it has required facilities to be above the medians at a high enough percentage to make sure that facilities must staff at what would be a safe staffing level in order to qualify.

### **Operating Expense**

Providers may earn one point for low operating expenses. Providers with per diem operating expenses below 90 percent of the statewide median per diem operating expense will earn one point.

### **Staff Turnover**

Providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff (director of nursing, registered nurse, licensed practical nurse, licensed mental health technician, and aides) turnover equal to or below the 75th percentile statewide will earn two points. Providers with direct health care staff turnover equal to or below the 50th percentile statewide will earn one point. Contract labor is an excluding factor from the turnover criterion: contracted labor costs cannot exceed 10 percent of the provider's total direct health care labor costs.

### **Staff Retention**

Providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 73 percent, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 64 percent, the 50th percentile statewide will earn one point.

### **Occupancy (Total and Medicaid)**

Providers may earn up to two points for their occupancy outcome measures. If they have total occupancy greater than or equal to 90 percent they will earn one point.

Each provider is awarded points based on their outcome measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation. Thirty-eight percent of the nursing home providers have received a quality incentive factor of \$1.00, \$2.00 or \$3.00 in their Medicaid per diem rate.

### **Documentation Required**

The most recent cost report data for each provider are used to determine these outcome measures. These cost reports are field audited and the state focuses on those providers receiving the adjustment. The state asks the facilities to provide the following information on the cost reports for staff turnover and retention: beginning number of employees, number of employees hired, number terminated, ending number of employees, number part-time and number full-time, number of employees retained, percent of turnover and percent of retention. This is required for all employees by position. There is a two year lag between performance (data year) and award year. Thus, incentive awards given in 2006 were based on data from 2004.<sup>18</sup>

State staff explained why they included these staffing outcomes in the initiative. They stated that research has shown low staff turnover and high staffing ratios are correlated to quality of care. Staff turnover causes training and recruitment costs to increase, so low staff turnover should reduce those expenses. The state also believes that high occupancy can be associated with consumer satisfaction.

### **Survey Outcomes**

There are two criteria for survey outcomes. Homes will receive two points if they have a deficiency free survey and remaining homes that have no more than five deficiencies, none of which is greater than a scope and severity of E (deficiency which has caused a pattern of harm), receive one point.

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<sup>18</sup> Bott, M., Dunton, N., Gajewski, B., Lee, R., Boyle, D., Bonnel, W., Averett, E., Becker, A., Coffland, V., Wrona, M., Chapin, R., and Rachlin, R. Trends In Kansas Nursing Facility Turnover After The Implementation Of A State Incentive Program, For the Kansas Department on Aging, By the Kansas Nursing Facility Project, University of Kansas, September 16, 2008

State staff believes that this initiative has met its goals. They feel that providers are concerned about how to improve their performance on these outcome measures and many of the statewide statistics have gradually increased. One respondent to our follow up survey of consumer/ombudsmen groups in Kansas stated that the criteria of operating expenses should not be included (“it has nothing to do with quality”) and another criterion should be added: consistent nurse staffing, which has also been shown to improve both quality of care and life.

### **Evaluation of the Program**

The state asked the University of Kansas to evaluate the incentive’s success in lowering staff turnover.<sup>19</sup> The study found that:

- In 2009 (performance data year 2007), nursing facilities earned an average of just over 3 incentive points out of a possible 9.
- Total staff turnover in Kansas nursing facilities declined between 2001 through 2004, the period prior to the implementation of the incentive program. In the two years following program implementation, the turnover rate increased.
- Turnover trends differed by job title, but the incentive program did not appear to have a positive effect for any category of nursing staff. Turnover among RNs increased from 60 percent in 2001 to 69 percent in 2006. LPN turnover declined from 68 percent in 2001 to 63 percent in 2003, then in 2004, the year prior to program implementation LPN turnover rates began to rise, reaching 65 percent in 2006. Turnover rates among certified nursing assistants (CNAs) declined significantly from 102 percent in 2001 to 87 percent in 2004 then rose by 5 percentage points to 92 percent in 2006.
- The incentive program did not appear to promote organizational change for any type of facility, but it could have rewarded the ones that already had lower turnover rates.
- Nursing facility turnover rates are driven by turnover of certified nursing aides, the largest occupational group. Aide turnover may be strongly affected by economic trends. Trends in nursing facility staff turnover bore an inverse relationship to trends in the Kansas unemployment rate. Thus, any beneficial effect of the incentive program could have been overshadowed by economic circumstances.

The study made the following recommendations. The state should consider:

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<sup>19</sup> Ibid.

- Offering incentive points to facilities that improve their outcomes, in addition to offering points for achieving certain outcome levels.
- Educating nursing facilities across the state about the various elements of the program and providing examples of the potential levels of benefit.
- Decrease the lag from performance to reward to one year.
- Focusing the program on fewer outcome measures to communicate priorities.

### **Wage-Pass Throughs**

Kansas had a wage pass-through program that began on September 1, 1999 and ended on June 30, 2001. It was driven by provider initiated legislation. The intent was to increase staff compensation and thus, hopefully, reduce staff turnover. Providers applied for a per-diem add-on to their rates. The amount of funds in the program was pro-rated so that all eligible providers received some funding. Facilities could spend the funds on wage increases, bonuses or new staff. Providers then submitted reports demonstrating enhancements they had made to compensation for qualifying staff positions (direct care staff). State staff indicated that they did not believe this initiative was successful. The state found that staff turnover did not decrease significantly and that some providers used the pass-through in place of annual cost-of-living increases which contributed to wage inflation. Since the goal was to increase staff compensation over what would have ordinarily been given, state staff believe that the pass-through funds supplanted regular wage increases. State staff indicated that it would have been better to require that the funds be used for bonuses rather than increased compensation. Consumer response to our follow up survey agreed with state staff on this.

### **Efficiency Incentives**

Kansas uses ceilings with the direct care ceiling higher than the indirect or operating cost centers.

### **Future Initiatives**

The state is looking into Pay for Performance and using the Fair Rental System for Property rates.

## MARYLAND

Maryland's case-mix system has been in place since the 1980s. Maryland has 216 nursing homes with 23,092 residents of which 61 percent are on Medicaid.

Maryland does not use the RUGs model. Using components of the Minimum Data Set Version 2.0, Maryland's system is based upon a resident's dependency in Activities of Daily Living (ADLs) and need for and receipt of ancillary nursing services. Using mobility, bathing, dressing, continence and eating, each recipient is assigned a reimbursement level depending on his or her degree of dependency in ADLs and classified into one of four groups: Heavy Special Care, Care, Heavy Care, Moderate Care and Light Care. The system has four cost centers: Nursing Service; Other Patient Care; Administrative and Routine; and Capital. In addition to the rate based upon the resident levels of need, facilities may also be reimbursed for ancillary services.

### Quality and Access Incentives

#### Encouraging Licensed Nursing and Medical Services

Maryland encourages special licensed nurse care. According to interviewed state staff, when the system began in the 1980s, many individuals were backing up in hospitals and the state wanted to encourage their admittance to nursing homes by paying more for skilled nursing care. For most of the services given enhanced reimbursement, the state has been careful to detail the criteria the home has to follow in order to qualify and how it must document that such care was needed and actually given. Thus, the state is encouraging both access and quality and holding providers accountable for care. Below are the services the state has decided to focus on:

#### Decubitus Ulcer Care

- *Enhanced reimbursement for treatment of severe ulcers.* According to state staff, the general reimbursement rate covers care for a stage I or II ulcer. The added reimbursement is only for care of a stage III or IV ulcer or similar condition, but only if it is documented not to be the result of poor care in the facility. The state requires the facility to document either that the condition was present upon the resident's admission or that it is not the result of inadequate or inappropriate care by the facility. If a decubitus ulcer develops even with preventative treatments, the facility will be reimbursed only if it documents that such development was inevitable. In

addition, the facility is required to show physician notes documenting periodic review of the resident's status and the treatment plan. The state has a list of types of treatment that can be used and key documentation that must be provided to the state.

- A crucial issue is whether facilities with residents with stage III or IV ulcers that are determined to have been caused by inadequate care in the facility will give these residents the care they need to treat these problems without receiving additional reimbursement to do so. State staff indicated that it is relying on the inspectors who annually inspect nursing homes to monitor this.
- *Enhanced reimbursement for support surfaces.* This includes mattress replacements and pressure reducing support surfaces with an inflated cell depth of at least five inches.

In order to be eligible for reimbursement, the facility must meet the criteria for reimbursement of decubitus care (see above). In addition, the surfaces must be ordered by a physician; the records must document their use according to physician's orders; and the care plan and all documentation must show the facility is providing overall health care services to heal the ulcer and prevent recurrence. The state lists quite a number of specific key documentation that must be presented.

- *Enhanced reimbursement for negative pressure wound therapy.* Maryland initiated an enhancement that began on October 1, 2007. This applies only to treatment of stage III and IV ulcers and must follow criteria stipulated for reimbursement for decubitus care (see above). In addition, the facility must document that traditional methods did not heal the wound or, because of the resident's medical condition, traditional methods will not work or are contraindicated. Here too, the state lists a number of key documents needed to be provided and some specifics of how to use the therapy.

The state has not evaluated the success of these initiatives as of yet. In a follow-up survey LTCCC conducted of consumer representatives in Maryland, one respondent questioned whether the state's focus on decubitus ulcers has been successful: "Maryland has been doing this for some time. If it were wildly or even mostly successful, we wouldn't have one of the highest high-risk, long-stay pressure ulcer rates in the country."



**Turning and Positioning**

In order for the facility to qualify for this enhancement, the resident must require 24 hours of turning and positioning and must be on a two hour turning and positioning schedule. In addition, the state requires a licensed nurse to document on each shift that the resident has been turned and repositioned.

**Tube Feeding**

This must be the primary method of feeding. Care must be documented.

**Ventilator Care/Suctioning/Tracheostomy Care**

Ventilator care can only be provided in a facility authorized to provide ventilator care. Care must be documented.

**Communicable Disease Care**

The facility must document that they are giving physician-ordered individualized treatments in order to qualify for the enhancement and must document that care was given.

**Oxygen/Aerosol Therapy**

Care must be physician ordered and provided by a licensed nurse or registered respiratory therapist. Care must be documented and be signed by licensed medical personnel for each shift for which care was provided.

**Therapy Services**

In order to qualify, the resident must need a qualified therapist to perform or supervise the therapy; it must be physician ordered; and it must be restorative. Proof of provision of therapy is required.

**Central Intravenous Line and Peripheral Intravenous Care**

In order to qualify, the care must be physician ordered and frequently evaluated and must be administered and monitored on a 24 hour basis by an RN. All other staff must be adequately trained. All care must be documented showing appropriate dressing changes and treatments must be signed off by the licensed professional performing the procedure.

## Quality Incentives

### Counteracting Negative Incentive Not to Care for Residents

Maryland has an initiative to attempt to ameliorate the fact that the case-mix system may not encourage facilities to help residents improve or maintain their function (their rate drops if they do). In addition, this initiative recognizes that when a resident improves it is difficult to immediately cut costs. Maryland continues to pay a facility at a higher case-mix rate for two months if a resident, who has been in the higher group for at least two months, improves and therefore is placed in a lower paying case-mix group. Here too, unfortunately, the state has not conducted any evaluation of this initiative to see if it is meeting its goals.

### Pay for Performance

Maryland is considering implementing a Pay for Performance (P4P) initiative. They read the report that LTCCC released in 2008<sup>20</sup> and are considering developing a program where facilities would have to meet multiple criteria in order to receive an award rather than improve on only one indicator (a problem with some P4P programs identified in the report).

## Efficiency Incentives

Maryland uses ceilings and gives facilities a percentage of the difference between their costs and the ceilings in Administrative and Routine costs and Other Patient costs centers. It does not permit this in the Nursing cost center.

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<sup>20</sup> An Assessment of Pay for Performance for Nursing Homes With Recommendations for Policy Makers, <http://ltccc.org/publications/documents/LTCCCP4Preportfinal08.pdf> (2008).

## MINNESOTA

Minnesota uses RUGs III-34 group model, is cost based and has five cost centers: Nursing Services, Other Care Related Services, Other Operating, External Fixed and Property. The state has 388 facilities participating in the state's Medicaid program, serving 30,264 residents of which 57 percent are on Medicaid.

### Quality Incentives

Working with the University of Minnesota, Minnesota has implemented a three-pronged approach to improving quality in its nursing homes.

#### Use of Nursing Home Report Cards

As a result of legislation (2001) the state developed a report card for each nursing home and publicly reports this information. By publishing information about quality of care in nursing homes, the state hopes that all facilities will strive to get the best scores possible. This report card (see <http://www.health.state.mn.us/nhreportcard/nhreportcardfactsheet.pdf>) lists seven quality measures to help the public compare nursing homes. The seven indicators are:

- Resident satisfaction and quality of life.
- Quality indicators – clinical quality.
- Hours of direct care.
- Staff retention.
- Use of temporary nursing staff.
- Proportion of beds in single bedrooms.
- State inspection results.<sup>21</sup>

Each nursing home can receive from one to five stars on each measure. According to state documents, a great deal of effort goes into making sure the data reported by facilities or gathered through other means are gathered consistently, in accordance with detailed definitions. The statistics have been compiled using methods developed at and, in some

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<sup>21</sup> An eighth measure, direct care staff turnover, was dropped from the report card in October 2006. According to state staff, this measure was dropped from the report card for methodological and conceptual reasons. Turnover was difficult for the state to define, for providers to accurately give the needed information to calculate it, and for both sides to reliably calculate it and get the same result. Turnover was also seen as confusing and a bit redundant to some when retention and total staffing hours were already included.

cases, with consultants from, the University of Minnesota. Much of the information was provided by nursing facilities but is subject to audit by the state.

Four of the seven measures (resident quality of life/satisfaction, risk-adjusted quality indicators, direct care staff hours per day and direct care staff retention) have stars assigned based on the distribution of the results for all Minnesota nursing facilities. For each of these measures, the mean is determined and stars are based upon the facility's standard deviation from the mean.

### **Resident Satisfaction and Quality of Life**

Resident satisfaction and quality of life interviews are conducted in all nursing facilities on an annual basis. Using a standardized interview protocol, trained interviewers employed by an independent contractor of the state interview a sample of residents in each facility. The interview measures:

- Comfort.
- Environmental adaptations.
- Privacy.
- Dignity.
- Meaningful activity.
- Food enjoyment.
- Autonomy.
- Individuality.
- Security.
- Relationships.
- Mood.<sup>22</sup>

A summary score is constructed by calculating an average score for each domain, then finding the average of these domain scores. The summary score is then risk-adjusted (using age, gender, length of stay, cognitive ability, activities of daily living, facility location and

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<sup>22</sup> The domain "Spiritual Well-Being" was dropped after the initial wave of interviews in 2005. According to state staff, the domain included two questions and asked if the resident participated in religious services at the facility, and if the offered religious services were meaningful to them. These questions seemed to assume that attending and being satisfied with services is the desired outcome when residents may not want to attend. Also, interviewers and observers reported that many residents were uncomfortable with this domain because it is so personal in a way the other domains are not.

percentage of short stay residents) to level the playing field among all providers, controlling for resident and facility characteristics that are generally not a result of provider performance. See: <http://www.health.state.mn.us/nhreportcard/technicaluserguide.pdf> for more details.

### **Use of Quality Add-Ons**

Minnesota has an initiative where facilities who meet a combination of certain criteria receive adjustments to their rates. Since this is coordinated with the state's report card, funding for this initiative uses the same indicators as the report card. Thus, the state makes sure that any funding given to nursing homes has the same goals. With experience the state adds and changes criteria each year. Thus, in 2006 the criteria, with the percentages (weights) for each, included:

- Quality indicators – 40%.
- Direct staff turnover – 15%.
- Direct staff retention – 25%.
- Temporary staff usage – 10%.
- Inspection findings – 10%.

In 2007:

- Quality of life – 20%.
- Quality indicators – 35%.
- Staffing levels – 10%.
- Staff retention – 20%.
- Temporary staff usage – 5%.
- Inspection findings – 10%.

Staffing information is gathered from the cost reports submitted by facilities. According to state staff, this has been very successful. Quality of life and care has improved. In a follow-up survey with consumer representatives in Minnesota, one respondent felt that higher thresholds should be set: "Set a higher standard for care across the board and if it is met then the incentive should be given."

### **Tying Reimbursement Directly to Quality**

Minnesota will, in the next few years, once rebasing is phased in, use scores from its nursing home report card as it develops limits on certain cost centers. It will permit more

spending if quality is high. The higher the facility's quality score, the higher its cost limits will be.

### **Use of Pay for Performance**

Facilities are given funds for submitted project proposals that the state deems worthy of funding. State evaluates what the facility said it would do and if it does not, 1 percent of the funding is returned to the state.

### **Efficiency Incentives**

The state uses ceilings and facilities can keep 50 percent of the difference (up to a maximum of \$3 per resident per day) between the cost and the ceiling for each of the cost centers *except the direct care cost center*. State staff believes that the state does not want to encourage less spending in the direct care cost centers.

## MISSISSIPPI

Mississippi's case-mix system has been in place since 1993. Mississippi has 200 nursing homes with 36,696 residents of which 77 percent are on Medicaid. Mississippi uses RUGs III-34 group model is cost based and has 6 cost centers: Direct Care; Care Related; Administrative and Operating; Property; Hold Harmless and Return on Equity.

### Access Incentives

#### Alzheimer Residents

Mississippi gives providers an incentive to build Alzheimer units. It acknowledges that it costs more to care for a resident in a unit than in the general population. The state gives higher weights for Alzheimer residents in certain RUGs categories only if they are cared for in an Alzheimer unit. These are some of the Clinically Complex (and Clinically Complex with Depression), Cognitive Impairment, Behavioral Problems and Physically Functioning categories. In addition, Mississippi gives facilities with an Alzheimer unit a higher fair rental value for their capital costs. State staff believes that this initiative has been successful. A number of units were put in place.

#### Heavy Care Residents

Mississippi has an incentive to encourage facilities to admit heavier care residents. When the system began in 1993, there was a major backup in hospitals and many people were having trouble getting admitted to a nursing home. Most facilities had a waiting list. The RUGs weight of a number of selected groups was increased by 2 percent for those facilities spending in direct care and care related costs above the floor. The 2 percent enhancement to certain RUGs categories is only available to facilities whose case mix adjusted direct care and care related costs are greater than or equal to 90 percent of the median for the cost report period being used to compute the base rate.

The state has no specific programmatic criteria a facility has to follow in order to be eligible for this increase other than admitting individuals in these categories.

### Quality Incentives

For two years, in 1994 and 1995, the state implemented an initiative to encourage providers spending below the floor to spend at least at the floor in direct care. The state gave providers who were spending below the floor in the Direct and Care Related

components the floor rate. However, the state stipulated that if the providers did not increase their spending in these areas, they would have to return the funds to the state. The idea was to give providers an opportunity to have upfront funds, while urging them to spend in direct care. Upon evaluation, the state found that while some facilities spent the additional funds, others did not. The intent was to offer this initiative only once to encourage spending in direct care. State staff indicated that there were many problems in recovering funds not spent.

### **Use of Civil Monetary Penalty (CMP) Funds**

Mississippi offers facilities additional funds from their CMP account (made up of fines for poor care) in the form of grants for specific projects to improve nursing home care. This is not open to facilities that give poor care as determined by the inspection system.

### **Efficiency Incentives**

Mississippi gives providers an efficiency incentive in the Administrative and Operating costs cost center. If a facility's costs fall below the ceiling, then its Administrative and Operating rate is its trended cost plus 75 percent of the difference between the greater of the trended cost or the median and the ceiling. This incentive is not included in the direct care areas. This initiative has not been evaluated.

Under the premise that higher occupancy levels mean better efficiency, Mississippi encourages higher occupancy levels by calculating total patient days at a minimum of 80 percent occupancy. Staff believes that this has been successful.



## TEXAS

Texas has recently changed its Medicaid nursing home reimbursement system to RUGs III with 34 groups (September, 2007). According to state staff, it was changed for a number of reasons. One, RUGs III has been updated by the federal Centers for Medicare and Medicaid Services (CMS). The state also wanted to be able to compare itself more easily to other states and cut paperwork by requiring the federally required assessment tool used for reimbursement to be used as well for care planning (instead of the tool the state had been using). In addition, state staff indicated that RUGs III has more variation. It did not choose RUGs III with 53 groups as New York is doing because the state believes the 34 group model is more appropriate for Medicaid in Texas as Texas has little Medicaid covered rehabilitation (which the additional categories cover). Texas' system has five cost centers: Direct Care Staff, Other Recipient Care, Dietary, General/Administrative and Fixed Capital Assets. The state has 1149 nursing homes caring for 86,698 residents with 65 percent on Medicaid.

### Access Incentives

Texas has an add-on for ventilator-dependent residents. They have had this for about 15 years. To qualify, a resident must require artificial ventilation for at least six consecutive hours daily and the use must be prescribed by a licensed physician. The add-on for residents requiring continuous artificial ventilation is 100 percent of the per diem ventilator rate supplement. The add-on for residents requiring artificial ventilation for at least six consecutive hours daily is 40 percent of the per diem ventilator rate supplement. Facilities are not required to meet any specific programmatic criteria in order to receive the add-on other than admitting ventilator-dependent residents.

In response to interview questions, state staff indicated that they believe this add-on was implemented to encourage access for ventilator-dependent residents. There were initially only a few facilities in the state willing to take these residents and since Texas is a large state, there was a large distance between them. This meant that many residents were forced to go into facilities far from their homes, families, and support structures. One of the most significant questions the state is now raising about this incentive has to do with quality.

According to state staff, there is evidence that some facilities taking ventilator-dependent residents have had major quality problems (two have had to be shut down). According to

state staff, the federal Centers for Medicare and Medicaid Services (CMS) has also been concerned with this.

## Quality Incentives

### Increasing staffing numbers/staff compensation

Texas has an incentive to encourage facilities to increase direct care staffing and/or compensation to direct care staff. Facilities can enroll in an enhanced staffing program by committing to staff their facilities above the state average and/or compensate their workers above state averages. Facilities are required to fill out annual staffing and compensation reports which reflects the activities of the facility while delivering contracted services from the first day of the rate year through the last day of the rate year. This report is used as the basis for determining compliance with the staffing requirements and recoupment amounts. All of these reports are audited and some are field audited. This initiative has been in effect since June 2000.

This was a legislative initiative. Stakeholders believed that it was crucial to increase staff to improve quality. By allowing facilities to receive this enhancement by either increasing staffing or increasing compensation, facilities are given the flexibility to make changes in ways that make the most sense for their geographic location. For example there are staffing cost differences in various parts of the state and some facilities might want to apply the additional reimbursement to higher compensation. When asked if this program has been successful in raising staffing levels, state staff felt that it did. However, the state has not looked into this for five years. It examined staffing levels two years after the program began in 2000 and found that it was successful. The state hopes to evaluate it again soon. However, research indicates that although staffing levels are rising, this is true nationwide and Texas' rates are still below the national average.<sup>23</sup>

In addition, state staff indicated that there were unintended consequences with this initiative. The funding for this initiative is limited. Thus, the state is unable to accept new providers into the program until all old providers are funded and they can't increase funding at higher levels. State staff believes that a competitive disadvantage has been created for some providers who cannot get funding. The response by a consumer

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<sup>23</sup> Harrington Charlene, Ph.D. Carrillo Helen, M.S., Wolesslagle Blank Brandee, M.A. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2001 Through 2007. Department of Social and Behavioral Sciences University of California. San Francisco, CA 94118, *September 2008*.

representative to LTCCC's follow up survey raises an important issue that must be thought about as states develop such incentives: since enhanced payment is based upon actual state averages rather than a good standard of care, the state is paying additional funds (\$75 million in 2005 to 948 homes<sup>24</sup>) to some nursing facilities to staff below industry recognized minimum safe staffing levels.

### **Performance Add-On**

Texas had a Performance Based add-on which gave money to facilities based on both their compliance with state and federal regulations and resident quality indicators. This lasted only a few years because of the fiscal crisis in the state. According to state staff, even when it was in place, they believed that the amount of funds available was not enough to effect change. The most any one facility could get was \$36,000 and most received less. In order to qualify, facilities had to be in the top 10 percent on 5 quality indicators as well as comply with regulations. Even though this initiative has ended, Texas still has a unit that focuses on quality. It has a quality website: <http://qmweb.dads.state.tx.us/> which has resources for facilities looking for best practices. It also has state staff that focuses on helping facilities with quality assurance.

### **Efficiency Incentive**

Facilities are paid a flat rate based on either the median or mean statewide costs depending on the cost center.

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<sup>24</sup> Texas State Auditor's Office in April 2005, #05-033, page 36.

## UTAH

Utah uses the RUGs III-34 group model and has three cost centers: Nursing, Operating and Property. The state has 84 nursing homes with 9416 residents of which 53 percent are on Medicaid. It uses case-mix for Nursing (59 percent of the rate), flat based for Operating (29%) and a fair rental system for Property.

### Access Incentive

#### Paying More for Behaviorally Complex Residents

Utah gives providers an add-on if they admit “behaviorally complex” residents. A facility must apply for this add-on. The add-on is approved if an assessment of the acuity and needs of the patient demonstrates that the facility is not adequately reimbursed by the RUGS score for that resident. Behaviorally complex residents are residents who are more demanding and more difficult. One of the issues raised by state staff is whether the criteria for eligibility are strict enough; many nursing home residents might be able to fit into this category. According to the regulations, "Behaviorally complex resident" means a long-term care resident with a severe, medically based behavior disorder, including traumatic brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, retention of information or decision-making skills, **or** a resident, who meets the Medicaid criteria for nursing facility level of care, and who has a medically-based mental health disorder or diagnosis and has a high level resource use in the nursing facility not currently recognized in the case mix.

### Quality Incentives

#### Encouraging Quality Improvement Plans

Utah sets aside \$1,000,000 annually to reimburse nursing facilities that have a quality improvement plan which includes:

- The involvement of residents and family.
- A process of assessing and measuring that 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.

Facilities can have no violations that are at an "immediate jeopardy" level at the most recent survey and during the incentive period to qualify.

Facilities have to give examples of how they have assessed and measured their plan and what improvements have been made. The goal of the incentive was to encourage quality improvement plans and to improve the resident experience. Planning and implementing culture change has been recently added to this initiative. State staff believes that this has been successful.

In a LTCCC follow-up survey with consumer representatives in Utah, one respondent stated that he "feels that long-term care facilities should not receive extra financial reimbursements for services that should be and are required by state and federal regulations."

### **Encouraging Facility Care Improvement**

Each year the state has targeted certain areas for a one time add-on for qualified facilities. Thus, for 2009 add-ons will be given for facilities who:

- Install enhanced nurse call systems which do not primarily use overhead paging such as: pagers, cell phones, personal digital assistant devices, hand-held radios, etc. which can be turned off only at the resident's location and which track and report response times.
- Purchase at least one new patient lift system capable of lifting residents weighing up to 450 pounds and one new heavy duty lift capable of lifting residents weighing up to 1,000 pounds or two heavy duty lifts.
- Purchase a new side entry bath that allows the resident to enter without having to step over or be lifted into the bathing area.

In 2008, add-ons were given to facilities to improve clinical information systems, heating, ventilating and air conditioning systems and residents' dining experience. Funds were given to facilities that:

- Purchased or enhanced clinical information systems which are better integrated, capture more information at the point of care and give more automatic reminders and include care plans, current conditions, medical orders, and activities of daily living, medication records, timing of medication, medical notes and point of care data tracking.

- Purchased or leased hardware to facilitate the tracking of resident care and integrate the collection of data into the facility's clinical information system.
- Purchased a new or enhanced heating, ventilating and air conditioning system (HVAC).
- Used innovative means to improve residents' dining experience such as meal ordering, changing dining times or hours, atmosphere, giving more food choices, etc.

Facilities may not receive more than its documented costs and the money comes from reducing the base rates which was done the same year the state legislature raised reimbursement rates so providers were in favor of this. Although this is a one-time add-on and there is no attempt to see if the use of the funds has improved care, it does permit the state to choose, each year, where it believes facilities should focus.

One consumer respondent to our follow-up survey was not sure if this initiative has been successful: "I haven't seen a significant change in the facilities related to the above use of money. I am not sure if the facilities have proper knowledge regarding this benefit."

### **Efficiency Incentive**

Operating costs are a flat rate with is a fixed dollar amount for all facilities.

## Survey of Ombudsmen and Citizen Advocacy Groups

In order to solicit information from the nursing home advocates in the other states that are now using case-mix reimbursement in their Medicaid nursing home reimbursement systems we developed an on-line survey. The survey asked questions related to the relationship between the case-mix system and quality care, specifically asking for information on reimbursement incentives for good care. It also asked for information on other (additional) sources of public funding for nursing homes such as pay for performance, grants, or add-ons for special Medicaid residents or for other reasons and their impact on care. In addition, the survey provided space for respondents to give suggestions for modifying their case-mix reimbursement systems in order to impact care. See appendix for a copy of the survey.

All state ombudsmen of case-mix states except New York State were sent a link to the survey by email (33). All identified citizen groups in these states were also sent an invitation to respond (28).<sup>25</sup>

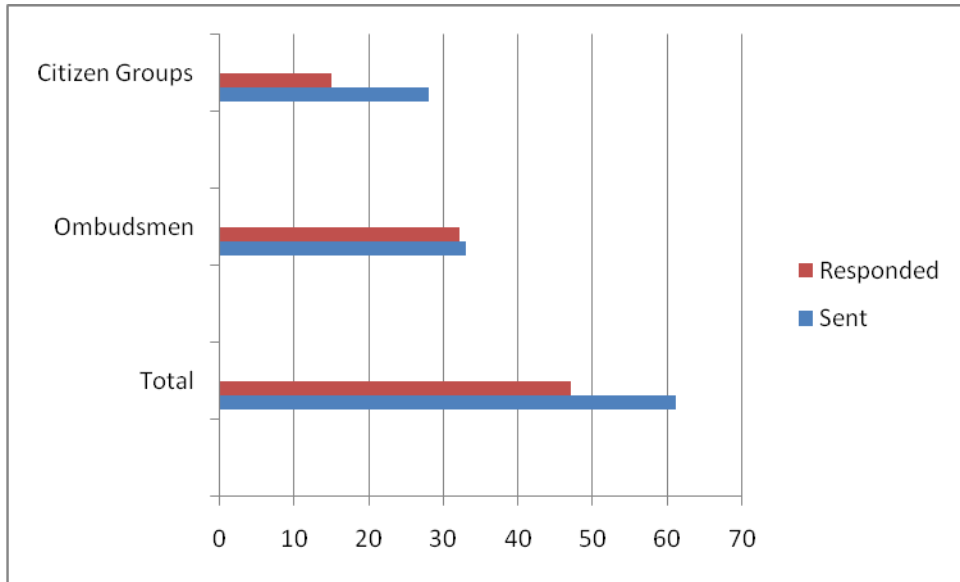
### Results

#### Response Rate Was Very High

The survey elicited a very high response rate, indicating that both Citizen Advocacy Groups (CAGs) and State Ombudsmen (SOs) are concerned about the relationship between the nursing home Medicaid reimbursement system and quality care. Nineteen (19) CAGs responded. This is a response rate of 68 percent. Thirty-two (32) SOs responded. This is a response rate of 97 percent. The overall response rate was 84 percent.

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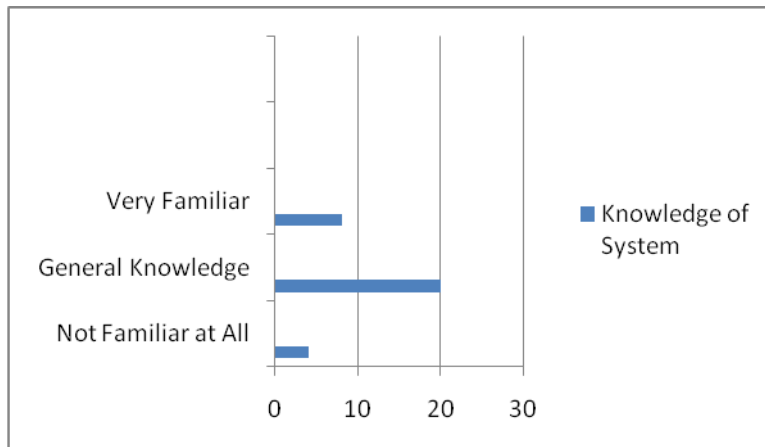
<sup>25</sup> The national long term care consumer organization, NCCNHR, keeps a list of such groups ([www.nccnhr.org](http://www.nccnhr.org)). In addition, we searched the internet for any citizen advocacy groups, checking each website to make sure they were in fact a citizen group. This list was then verified by NCCNHR.



### State Ombudsmen

#### Knowledge of the System

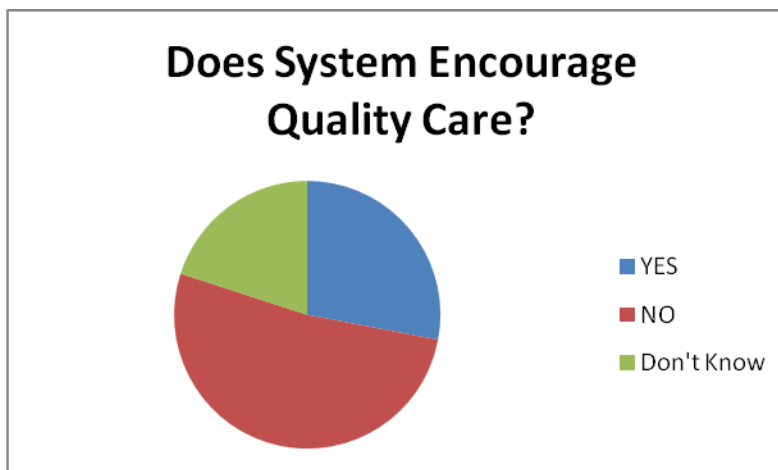
The responses from the SOs indicated that they were informed about their state systems. Sixty-three percent (20) of the state ombudsmen stated they had general knowledge of their state systems and an additional 25 percent (8) stated they were very familiar with the system. Only four stated that they were not familiar at all with the system.





## Encouragement of Quality Care

When asked: **Do you think your state's nursing home reimbursement system is structured in a way that encourages quality care**, a majority said **NO** (52%). Twenty percent said they did not know and 28 percent said, **YES**.



When asked to comment further, a number of the SOs felt that their state's system does have quality incentives built in, but either it was too soon to tell if they are effective, or they just did not know. Others raised concerns about how their systems are structured:

- "It would appear that it would be in the best financial interest of facilities to keep residents at a higher reimbursement rate."
- "A Nursing Facility is able to receive more funding the sicker the individual is. In some cases an individual may leave a hospital and if during the stay the person received IV therapy even though the person no longer receives such therapy the Nursing Facility may charge at a higher rate for a specific period of time."
- Our system "lacks incentives for resident directed care."
- "We use a case mix reimbursement system which should encourage better care...but the more needs an individual has the more reimbursement received does not necessarily do that."
- "Payment groupings based on diagnoses narrows focus to reimbursement only, not on general well being of each person."
- "Planning care is more reimbursement focused then resident focused."

Others felt that the problem lied in the fact that the payments were not high enough to pay for the care:

- “The plan limits are low and have not met or kept up with the rising cost of care in facilities. As a result facilities are either closing or turning to private pay.”
- “The amount that a nursing home receives from Medicaid is considered to be ‘comprehensive’ reimbursement. In other words, it is to pay for all of an individual Medicaid resident's necessary care and services. However, some necessary care, i.e., dental services, is not a Medicaid covered service. Residents who need these services find themselves doing without. Often because they have no way to pay for the necessary care. Nursing homes report that the reimbursement they receive barely covers the actual cost of bare minimum services and does not leave them any room to excel.”

### **Additional Public Sources of Funding**

When asked about the impact on quality of the additional avenues of public funding, those respondents that had knowledge were divided or unsure, as the perceptions of pay for performance indicated:

- “Encourages.”
- “Too early to tell.”
- “The encouragement of quality care depends on the original intent of the Nursing Facility which may not always be publically known. The provider with a deep systemic commitment to culture change within the Nursing Facility utilizes any and all additional funds towards the improvement of care for the residents.”
- “Too new to know.”
- “Nursing Facilities have an opportunity to apply for funding that enhances quality programming or supports implementation of state of the art practices unlike the traditional model.”
- “Use of CMP funds has provided incentives for Nursing Facilities to apply for performance incentive funding. This is a process where providers may submit proposals that focus on an element of improving quality of life/care.”

In addition, one ombudsmen does not believe in paying providers extra for quality:

- “Nursing homes should not be paid extra for doing what they are supposed to do. The reimbursement system should provide reimbursement at a sufficient level to allow them to do this.”

For Grants:

- “Culture change grants do encourage quality.”

For Add-Ons:

- These are “not related to quality care but special needs such as ventilator dependent care in less than quality care Nursing Facilities.”
- “Enables nursing homes to meet staffing ratios and implement certain quality improvements.”
- “Is neutral.”
- “The add-ons are limited and went to the savviest operators, but appear to have no effect on quality.”

### **Suggestions for Modifying the Case-Mix System**

Two common themes among a number of the ombudsmen were that the reimbursement system should improve staffing levels (and provision of worker benefits) as well as promote culture change innovations. Others were concerned that the incentives, while identified as quality incentives, were not truly quality incentives:

- “They need to be true quality incentives. [Measurement of] satisfaction is one of those that are used here but others such as occupancy rate aren’t necessarily an incentive to improve quality.”

Two ombudsmen had some other specific ideas:

- “Pay for healed pressure ulcers; provide state survey agencies with funding for specialized training provided on-site, exclusively for facilities providing ventilator care or those providing ‘certified Alzheimer’s’ care. Provide grants for new construction of small nursing homes and homes that demonstrate person-centered care.”
- “Paying facilities extra money for reaching goals of [having] very minimal pressure ulcers or incontinence, etc. would be helpful.”

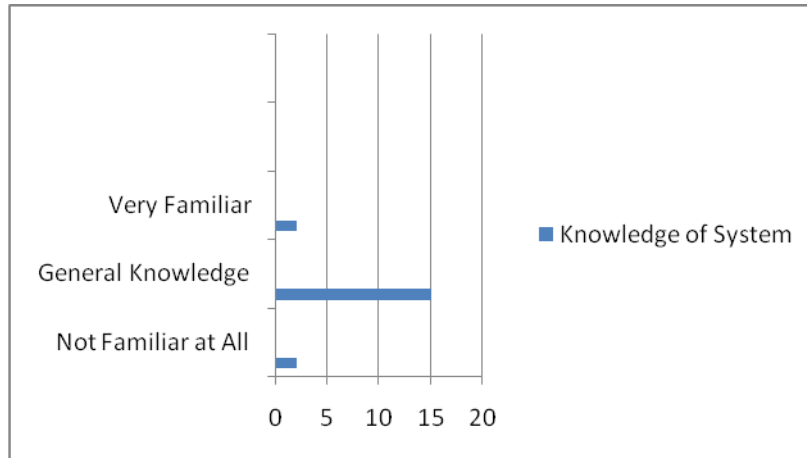
One ombudsman didn’t offer any modifications because she/he did not believe that the reimbursement system affects quality at all:

- “I frankly think that the reimbursement system has little to do with quality of care. Some facilities do quite well under current systems and some are terrible. I doubt that a different/improved system would improve the quality of care provided by those very poor performers.”

### Citizen Advocacy Groups

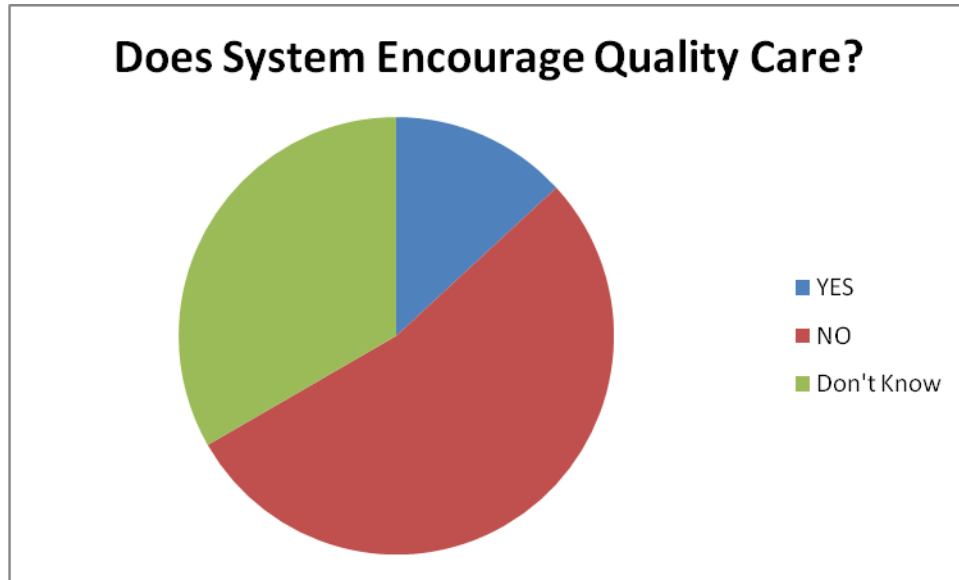
#### Knowledge of the System

The responses from the CAGs indicated that, although they said they are not as informed about their state systems as the SOs said, most knew enough to respond to the survey. Seventy-nine percent (15) of the CAGs stated they had general knowledge of their state systems and an additional 11 percent (2) stated they were very familiar with the system. Only 11 percent (2) stated that they were not familiar at all with the system.



#### Encouragement of Quality Care

Similar to the SOs, when asked: **Do you think your state's nursing home reimbursement system is structured in a way that encourages quality care**, a majority said, **NO** (53%). Thirty-three percent did not know and 13 percent said **YES**.



CAG comments were much more negative than the SOs about the system and whether quality care is encouraged. In addition, the majority of CAG respondents who provided further comments expressed disappointment with the system.

- “Actual performance for items paid for not checked by outside sources.”
- “There is not an incentive to keep residents functioning at the highest level potentially possible. Nursing facilities seem to terminate physical and occupational therapy easily particularly if they run into some resistance from the resident.”
- “(The system) does not encourage better care to improve health and life.”
- “The state has a very stringent Medicaid admission policy and the reimbursement rate is one of the lowest in the nation. We believe the use of case-mix fosters neglect, inadequate staffing, and rewards poor care.”
- “The accountability factor is not based on performance and outcomes.”
- “We have a case mix system - encourages providers to admit particular residents and not others - there is no incentive linking reimbursement to quality.”
- “The enforcement is spotty.”

#### **Additional Public Sources of Funding**

When asked about the impact on quality of the additional sources of public funding, these respondents that had knowledge also were divided or unsure.

Two CAG respondents felt that add-ons were not effective:

- Our state “raised a matching provider tax with the promise from the industry that they would use it to provide better quality care. They didn't.”
- “Add-ons seem to be a game to play.”

### Suggestions for Modifying the Case-Mix System

- “We feel that the nursing homes in our state are being sufficiently reimbursed to provide quality care with the system we have in place now. But they continue to poor-mouth their situation while at the same time raking in immense profits. There was a suggestion one time to tie their reimbursement in the state budget to minimum staffing standards, but the fellow who wanted to do that did not win his race for governor.”
- We should, “require proof of performance verified by outside sources. The refusal of payment for poor outcomes such as pressure ulcers and other actual harm deficiencies sounds good.”
- “I like the idea of paying a facility a bonus for having no incidents of decubitus ulcers in a month as this may also encourage facilities to maintain [resident] independence. Incentives for keeping residents physically active would be good too.”
- “A system based on outcome i.e. skin integrity, nutrition, safety, psycho-social wellbeing.”
- “I think that it makes sense to tie reimbursement to the amount of time spent on individual residents, so long as there is adequate auditing. I think this would make more of a difference to residents if at least some of any increased reimbursement had to be passed on to direct-care staff.”
- “Payments should only be increased if the money is spent directly on care at the front line caregiver. Performance payments should be based on how many people work the ‘front line’ to deliver care. Medicaid/Medicare and private dollars should be restricted in usage and more strategically placed at the point of service delivery. Cost basis accounting, setting thresholds for how much can be spent on certain expenses would force a shift in the way nursing homes do business. Recognizing there is a delicate balance between private enterprise and government contracts, it’s the accountability piece that always seems to be missing. The key to any successful changes in reimbursement has to start at the assessment of what type of care do we expect for our elders and what does it cost. Instead of pumping money into a broken system that is outdated. Re-negotiate contracts to put in specific provisions of care.”

- “Funding based upon staffing above minimums; enhancing funding for better trained, licensed staff; I am concerned about linking funding to outcomes as this may discourage providers from accepting more difficult to manage residents although in some cases linking reimbursement to outcomes may be beneficial but should be used cautiously.”
- “Tie reimbursement directly to staffing levels, quality of care indicators such as restorative care, restorative feeding, documented movement every two hours, etc.” “We may be playing into the hands of the industry when we go to worrying about reimbursement. Our experience tells us that most facilities have the money to do a good job in caring for their residents but will not use it. They would rather skimp on care to build their bottom line. In short, the money is there. We need staffing standards, among other things, to make quality care happen.”

### Conclusion

The high response rate to our survey indicates that there is strong interest in nursing home reimbursement and the connection (or lack thereof) between payment for care and the quality of care. While the responses were wide ranging and diverse, overall they articulated a widespread cynicism toward the system, in particular the perceived failure of case mix systems to ensure that nursing homes are providing adequate care and quality of life, as required by federal law. Over half of the respondents said that their state’s nursing home reimbursement system is not structured in a way that encourages good care. This is a striking and alarming result; if the reimbursement system is not structured to effectuate good outcomes what *is* it doing?

In addition to revealing a widespread lack of faith in how the reimbursement system is structured, the suggestions and comments provide a number of keen insights into some of the functional problems in these systems, such as the disconnect between payment for care and key indicators of good care (like maintenance of adequate staffing levels, known to be a crucial criterion of good care, or performance on key quality indicators). Too often these concerns have been overlooked in policy debates, though they go to the heart of our long term care system’s purpose: to help people achieve and maintain their highest practicable physical, social and mental well-being. As policy makers increasingly recognize both the need to obtain value from the programs they are funding and the importance of consumer needs and desires (i.e., resident centered care, home and community based care movements) in the long term care system, the comments and recommendation we received

demonstrate the value – and necessity – of having a consumer voice “at the table” when addressing reimbursement issues.



## CONCLUSIONS AND RECOMMENDATIONS

New York State Medicaid pays for 72 percent of all nursing home days in the state, spending \$7 billion annually or 15 percent of the total state budget.<sup>26</sup>

As New York and other states study how public funds are being used in nursing homes, they must consider questions of access, quality and efficiency. New York State is presently attempting to reform the system to address these concerns. The findings from our project indicate that many states have not coordinated these three goals of access, quality and efficiency. Most seem to look at them as singular issues without considering how they are interrelated. There is a need for all states and New York to make sure that incentives built into the system for one goal do not conflict with one of the other two goals, and that all the goals support the primary goal of quality.

### Access

Access Issue #1: The importance of identifying whether there is a need to facilitate access to nursing home care and developing a plan to evaluate both the continued need and success of add-ons.

Although states are concerned about quality and efficiency, the findings from the case study states indicate that some states have not carefully evaluated whether the additional add-ons are needed to facilitate access for individuals with special needs. For others, the original implementation of add-ons was so far in the past that the reasons for the incentive are unknown to current state personnel. Few states with such an initiative have formally evaluated its success or continued need. Some of the access incentives were put in place not because the state identified a problem with access, but because providers lobbied their legislatures and governor. New York State is proposing this year to give add-ons to facilities for dementia residents and for residents with bariatric needs. As states give extra funds to encourage access, they must be sure not only that the add-ons facilitate access, but that the goals of quality and efficiency are also being met. Given the fiscal crises facing the states and federal government, this is not the time to waste Medicaid money.

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<sup>26</sup> Governor Paterson's 2009-1010 Executive Budget Briefing Book.

## RECOMMENDATIONS FOR ACCESS ISSUE #1

States should not give extra funds to facilities to admit certain residents without:

- Identifying a specific need to encourage access.
- Setting goals for the incentive.
- 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. What does the state want to accomplish?
- Once this incentive is in place, set up a formal mechanism to evaluate whether the add-on has met its goals. Dedicate resources to make sure that the evaluations are carried out for the duration of the incentive.

Access Issue #2: Access incentives cannot just encourage admission of individuals with special needs; they must also be linked to a facility's ability to meet those needs.

A second, critical issue surrounding access incentives relates to the need to tie these incentives to quality. If an incentive only encourages admittance of certain hard to place or special needs residents it is, in effect, missing the fundamental goal: to make it financially viable for facilities to provide the special or enhanced care services that such individuals need. Our findings indicate that most of the 35 states who are giving add-ons to encourage access do have rules and regulations regarding how service must be given in order to be eligible for the additional funds for special populations with diagnoses of traumatic brain injury, AIDS, ventilator dependency, etc to make sure that facilities accepting such residents will give them the care they need. The dangers of not setting requirements may outweigh the supposed benefits of encouraging access. One of our sample states is questioning whether by not doing so, it has jeopardized care (see Texas case study).

However, we have not found any state that has any rules governing the need to have positive outcomes. By requiring facilities to meet certain positive outcome goals such as percentages of residents weaned off ventilators or maintaining function in a brain injury

unit, states could encourage both access and quality care. For instance, although New York State's special rates for residents with special needs such as traumatic brain injury, AIDS, and neuro-behavioral symptoms have programmatic requirements, they do not have any required goals for positive outcomes. As a result, many people who could be improving may not be. In addition, New York State currently has proposed add-ons for residents with dementia and bariatric needs which, at this point, do not have any programmatic requirements or goals for positive outcomes attached.

## **RECOMMENDATIONS FOR ACCESS ISSUE #2**

All access incentives should include both programmatic requirements and positive outcomes. For each incentive, states should:

- Develop a set of programmatic requirements to make sure that the additional funds are spent on care.
- Establish goals related to positive outcomes based upon the need being addressed.
- Develop a process for working with those facilities that do not meet these goals to help them improve or exclude them from future add-ons.

### **Specific Recommendations for New York State:**

#### *For Special Rates for Special Care Units Which Have Programmatic Requirements:*

- Develop goals related to resident positive outcomes for each.
- 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 accepting such residents.

#### *For Proposed Add-ons for Residents with Dementia and Bariatric Needs:*

- Develop a set of programmatic requirements for each to make sure that the additional funds are spent on care.
- Develop goals related to resident positive outcomes based upon the goals the state wants facilities to meet in order to receive these extra funds.
- Develop a process for working with those facilities that do not meet these goals to help them improve or exclude them from future add-ons.

## Quality

Clearly, encouraging quality care should be the foremost goal of all the states. Especially in a time of fiscal crisis, states cannot afford to waste money on poor care. In addition, in a case-mix system, as residents get more dependent and frail, reimbursement increases. Thus, paying for poor care leads to higher payments. Encouraging quality can thus be seen as an efficiency incentive for the future.

Quality Issue #1: The need for states to encourage direct care spending and link enhancements to direct care reimbursement to outcomes through surveillance and enforcement.

A number of the states have corridors consisting of ceilings and floors in their systems to put limits on spending<sup>27</sup>. Those states using ceilings and floors manipulate them in a number of ways to try to influence both efficiency and quality by either encouraging or discouraging spending. Ceilings set a cap on reimbursement; facilities spending above the ceiling receive only the ceiling as reimbursement. Floors set a minimum on reimbursement; facilities spending below the floor are given the floor. One of the states with floors has modified this. Information gathered on Louisiana indicates that the state has a floor for its Direct Care and Care Related Costs and any facility that spends less than the floor must reimburse Medicaid for the difference between their spending and the floor, thus encouraging spending in direct care. In addition, most states using ceilings have higher ceilings for direct care costs than for other cost centers, which is another way of acknowledging that limiting spending in direct care may have consequences for quality since most of the costs in direct care areas are related to direct care staff. Many studies have demonstrated the relationship between numbers of qualified direct care staff and quality.<sup>28</sup>

States that do not use ceilings and floors control costs by using either a statewide or peer wide average cost as the basic rate. By not using ceilings or floors these states encourage facilities to cut costs by keeping costs at the average or even below. Currently, New York

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<sup>27</sup> For more detail on this see section below on efficiency incentives.

<sup>28</sup> Nursing Staff in Hospitals and Nursing Homes: Is it Adequate? Wunderlich, G.S., Sloan, F and Davis, C.K. Editors; Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes, Institute of Medicine, 1996.

State has ceilings and floors. The ceilings are the same for both the direct costs and the indirect costs. Thus, there are no differences between maximum reimbursements for direct or indirect costs. As discussed above, other the states have different ceilings for direct and indirect, recognizing the need to permit more reimbursement for direct care. However, New York does have different floors for the two cost centers. The floor for the direct care is lower than for the direct costs. Thus, providers' permitted profit based upon spending below the floor is less for direct costs than indirect costs. New York is proposing this year to limit spending even further by removing all its ceilings and floors and using a peer group average which will be a geographical regional rate. The impact of this is discussed below in the efficiency section.

Some states, acknowledging the crucial relationship between quality and staffing levels, give additional funds that are intended to go directly to direct care staff. However, some studies have demonstrated that some of these "wage pass-throughs" have not been effective<sup>29</sup> and one of the case study state officials indicated that he was disappointed that some of these additional funds went into normal contract negotiations between providers and workers, rather than increasing staff numbers or staff compensation as intended. Even though there is a lack of evidence of the effectiveness of pass-throughs, many state legislators are embracing wage pass-throughs as one of a series of potential options to increase staff.<sup>30</sup>

Encouraging spending in direct care does not guarantee quality care. Some states that encourage spending in direct care have instituted some initiatives to link reimbursement to their surveillance or enforcement systems or order to make sure that the funds lead to better quality. Minnesota is using scores from its nursing home report card as it develops limits on certain cost centers. It permits facilities to be reimbursed for higher costs if quality is high. The higher the facility's quality score, the higher its cost limits will be. Maine goes the other way by reducing a facility's reimbursement to 90 percent of its rate if a facility is found not to have provided quality care on its inspection. The reduction remains in effect until the facility's deficiencies have been corrected. Maryland pays for the care of stage III and IV decubitus ulcers only if it is shown that the ulcers were not the fault of facility care.<sup>31</sup> Maryland also continues to pay a facility at the higher rate for two months if

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<sup>29</sup> State Wage Pass-Through Legislation: An Analysis: WORKFORCE ISSUES: No. 1, Institute for the Future of Aging Services, U.S. Department of Health and Human Services, December 20, 2002.

<sup>30</sup> Ibid.

<sup>31</sup> This is similar to Medicare's new policy not to reimburse hospitals for "never events," events. As of October 1, 2008, Medicaid no longer pays for events that are the result of a hospitalization such as wrong-site surgeries, transfusion with the wrong blood type, pressure ulcers (bedsores), falls or trauma, and nosocomial

a resident improves (and thus moves to a lower-paying category or group) to encourage facilities to get residents better. While these practices may have some potential negative consequences (see Maryland case-study), these states are not merely encouraging spending in the direct care area; they are trying to make sure that this money is paying for good care.

### **RECOMMENDATIONS FOR QUALITY ISSUE #1**

- States should encourage spending in direct care.
- Links must be made to quality care through the states' nursing home surveillance system and enforcement systems.

#### **Specific Recommendations for New York State:**

- If the 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. In addition to considering the initiatives of Louisiana, Maryland and Maine, it could also 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 in-direct costs to offset additional expenditures in direct care.

### **Encouraging Quality by Earmarking Funds Directly for Quality**

Many of the states have begun to earmark special pools of Medicaid money to reward facilities for quality care (P4P money, civil monetary penalty money, and special Medicaid quality pools). By putting more and more fund into these pools, states have an opportunity to shift the nursing home reimbursement system from one solely based upon facility costs to one based more on quality outcomes. However, few of the states have formally evaluated these programs to see if they have been successful.

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infections (hospital-acquired infections) associated with surgeries or catheters. The hospital will be required to cover any additional expenses that emanate from the additional problems a patient has suffered. NYS has also implemented a similar program to deny or reduce Medicaid payments for a number of never events.

As states develop these programs, it is crucial that these programs be fundamentally coordinated with each other and the goals of access and efficiency in order to ensure that the funds are not wasted. It is unclear whether these states have coordinated these efforts with their access, efficiency or quality incentives. For example, Georgia has a quality initiative giving facilities additional funds if they excel in certain quality areas; at the same time they have an efficiency incentive in the direct care area that discourages spending in direct care. In addition, Georgia's enhanced staffing incentive rewards facilities for staffing above a specified level that studies have indicated is well below what is needed to provide safety and adequate care for residents.<sup>32</sup>

Minnesota is one state that has tried to bring all of their quality initiatives together by developing a comprehensive approach. The state created a nursing home report card, to report information to the public on nursing home quality. It then used the indicators on the report card as the criteria for distributing its quality pools of funds and will be using it to develop rates by relating the report card scores to cost ceilings (see Minnesota case study for more details). New York State's proposed Nursing Home Quality Pools initiative is a noteworthy step forward in shifting its reimbursement system from one focused only on facility cost to one focused on quality as well.

Quality Issue #2: The need to carefully structure quality pools of Medicaid funds.

As states consider how to move their reimbursement systems more towards paying for quality by earmarking specific pools of Medicaid money to go to facilities that meet or excel on certain indicators, they must consider a number of issues:

- Do the criteria chosen include a range and scope of indicia to adequately measure quality?
- Are the criteria chosen important to nursing home residents?
- If facilities are to be paid more for their performance in comparison to other facilities in the state (such as by the exceeding state average on a given criterion), rather than for meeting or exceeding recognized benchmarks of good care, what is

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<sup>32</sup> Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final, Volume I, Prepared for Marvin Feuerberg, Centers for Medicare and Medicaid Services. Prepared by Abt Associates Inc., 2001.

being done to make sure that quality standards are being met or exceeded, and facilities are not being rewarded just to do better than an average, which itself may be sub par?

- Does including temporary staff or agency nursing in staff levels reward quality?
- Which facilities, if any, should be excluded based upon poor care or non-compliance with rules and regulations?

Research on states' use of Pay for Performance (P4P) has indicated that having only a specific objective (or limited objectives) – such as a reduction in pressure ulcers (as New York State is currently proposing to CMS for its P4P) can actually cause harm by giving providers an incentive to focus on particular activities at the expense of others not measured in the P4P program.<sup>33</sup>

Most states earmarking pools of Medicaid funds to encourage quality have developed a variety of measures for facilities to excel in. A number of them also have chosen criteria that relate to residents' quality of life as well as quality of care. For example, Minnesota uses the following criteria:

- Quality indicators
- Direct care staff levels
- Direct care staff retention
- Temporary staff usage
- Inspection findings
- Quality of life

And Iowa's criteria include the following among others:

- Inspection findings
- Staffing hours
- Resident satisfaction scores
- Resident advocacy committee resolution rates
- Employee retention rates

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<sup>33</sup> Mollot, R., Rudder, C., Samji, N. An Assessment of Pay for Performance for Nursing Homes With Recommendations for Policy Makers: A special report of the Long Term Care Community Coalition, 2008.



All of the data gathered in this study indicate that every state that earmarks pools of funds to encourage quality is requiring facilities to meet or exceed state averages or peer group averages. Thus, facilities are compared to one another rather than to a commonly accepted quality practice. For instance, Minnesota arrays the scores of all facilities and then looks at an individual's deviation from the mean score. Ohio requires facilities to have resident satisfaction, family satisfaction and staff levels greater than the statewide average and employee satisfaction above a peer group average. New York State is proposing quality pools that will reward the top 20 percent of facilities on a number of different criteria. By comparing facilities only to each other, it is possible that facilities are being rewarded for poor practice if statewide averages are too low. On the other hand, one of the problems with using commonly accepted good standards is that there may not be a consensus about them. However, there are indicia, such as direct care staffing levels, that do have recognized standards and they should be included whenever possible. If there are not commonly accepted standards in a specific area that the state is interested in focusing on, other focus areas that do have accepted standards should be incorporated to ensure that the overall funding incentive encourages nursing homes to meet or exceed the federal standards that entitle every nursing home resident to receive the care that they need to achieve their highest practicable physical, social and emotional well-being. We also recommend that research be conducted on quality areas that do not have recognized standards so that such standards can be identified and utilized.

## RECOMMENDATIONS FOR QUALITY ISSUE #2

- States should choose a variety of valid and reliable criteria.
- The criteria chosen should relate to large numbers of residents.
- Include a consistent set of indicators each year to encourage facilities to improve in areas that the state has identified as important which are indicative of the overall level of care a facility is providing.
- Include a few new indicators each year based upon issues identified in state inspections and data collection.
- Rather than comparing facilities to each other, commonly accepted benchmarks of good quality should be used and if there are not commonly accepted practice in a specific area that the state is interested in focusing on, research should be conducted to find one and other focus areas that do have accepted standards should be incorporated.
- Limiting the use of temporary agency staff should be considered.
- All programs should be continually evaluated. Are they successful in meeting their goals? For this, it is crucial that resources be dedicated to evaluation.
- Facilities with major care problems should be disqualified from programs that provide additional funding.
- Over time, more and more of the reimbursement Medicaid funds should be directed toward these quality pools, thereby moving the reimbursement system towards a fully quality outcome oriented system.

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

- Add a number of other criteria such as resident and employee satisfaction that would be measured by an independent third party, and staff retention/turnover.
- Include a consistent set of indicators each year to encourage facilities to improve in areas that the state has identified as important which are indicative of the overall level of care a facility is providing.
- Include a few new indicators each year based upon issues identified in state inspections and data collection.
- Consider limiting the use of temporary agency staff in its measurement of staffing levels.
- Do not use facility reported data for staffing levels; use payroll data.
- Use the staffing level agreed to by most experts of 4.1 hours of nursing time per resident day rather than the top 20 percent.
- Consider adding a few other quality indicators to its list that affect more residents such as pain management and incontinence.

Quality Issue #3: The need to tie reimbursement directly to quality.

Some of the states have gone further than just encouraging spending in direct care or using Medicaid funds to reward quality care. A few of the states have tied the rate directly to quality. For example, Maine actually lowers a facility's rate to 90 percent of the rate if a facility has major care problems. This rate remains in effect until the deficiencies are corrected. Maryland does not pay for some care if the need for the treatment was found to be the fault of poor facility care. Both of these initiatives have potential negative consequences unless careful monitoring of care is done by the state. Minnesota will be computing rates based on quality by setting cost limits based upon scores from its report card. The higher a facility's quality score, the higher its costs limits will be.<sup>34</sup>

### RECOMMENDATIONS FOR QUALITY ISSUE #3

- New York State and other States should consider ways to directly tie reimbursement to quality by tying the rates to quality or similar to what Minnesota is doing by relating how much facilities will be reimbursed by how much quality of care they give.
- Initiatives by states attempting to do this should be examined and evaluated carefully. What are the pros and cons of Maryland not reimbursing for poor care similar to Medicare and Medicaid not paying for "never events" in hospitals or Maine reducing reimbursement based upon deficiencies?
- Each year move more and more of the Medicaid reimbursement funds into the quality pools.

### Efficiency

Efficiency Issue # 1: The importance of structuring the basic reimbursement system to encourage efficiency without creating disincentives to reduce costs that may affect quality.

There is no doubt that states have a strong interest in encouraging nursing facilities to operate in the most efficient manner possible because, in the end, they are responsible for paying for many of these costs. However, it is important that the goal of efficiency is not

<sup>34</sup> Under current law this will go into effect once rebasing is phased in.

achieved at the expense of quality of care. States using a case-mix reimbursement system have attempted to encourage the efficient operation of nursing facilities in various ways. Some place ceilings (caps on reimbursement) and floors (minimum reimbursement) on allowable costs; others reimburse all facilities at a single rate. With ceilings and floors, facilities spending above the ceiling, receive only the ceiling; facilities spending below the floor receive the floor. Thus, a facility spending above the ceiling will incur a loss; a facility spending below the floor will receive additional profit. This encourages facilities to keep their costs below the well defined limits in order not to incur a loss (by going above the ceiling) or to make a profit (by staying below the floor). Using ceilings permits facility costs to vary more widely than just using averages or medians as a 'cap.' Ceilings permit facilities to spend more than the average or median and therefore may encourage facilities to spend more. The use of floors may encourage facilities to spend less than the floor.

Some states have recognized that structuring the basic reimbursement system for efficiency in these ways may affect quality of care by limiting spending in direct care. These states have attempted to counteract this in a number of ways. Many of the states with ceilings in the study have put higher ceilings on direct care costs to permit higher spending in this area. For example, in Louisiana, the rate is set at 107.5% of the statewide median for Administrative and Operating costs and 110% of the statewide median for Direct Care and Care Related costs. Some states with floors do not permit facilities to make an additional profit in the direct care area by keeping the difference between their costs and the floor. Louisiana requires facilities spending below the floor in direct care to return the difference to the state.

The use of case-mix adjusted statewide or peer group medians as a flat rate for all facilities limits costs even further and creates an incentive for facilities to keep their costs at or below the median in order to avoid an operating loss or to make additional profit. This in turn will lower the median or mean reimbursable costs of all facilities in future years. Some states, concerned that this method might also hamper quality by limiting costs too much on direct care, have combined the two methods. For example, New Hampshire uses ceilings for the direct care cost center and a statewide median flat rate for administrative costs.

Currently the New York system uses both ceilings and floors in their direct and indirect care cost components, in effect creating a corridor of allowable costs within which facilities are reimbursed. The corridor is larger (floors are lower in the direct care center) in the

direct care cost component than in the indirect component, which permits more spending in that area and provides a disincentive to spend less.

The Governor of New York, in his Executive Budget for 2009-2010, is proposing to remove the ceilings and floors and replace them with a regional average rate. He is also proposing to give “losers” (facilities that will face a loss) in this new system “transition” funds to help them move to the new system. The use of a regional rate raises many concerns for resident quality of care and life. Will providers who are now spending above or near the ceiling cut staff or other spending that affect resident care or quality of life? Will facilities try to spend below the average to make an additional profit by cutting staff?

### **RECOMMENDATIONS FOR EFFICIENCY ISSUE #1**

- 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.
  - 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. 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.
- States using a single statewide or peer group wide rate for facilities should consider using ceilings and floors for direct care costs.
- States should have a formal process in place 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 – New York should:**

- Keep ceilings and floors for the direct care costs.
- 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.
- Carefully consider whether the only peer grouping should be regional. Are all differences in costs explained by regions alone?
- 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.

- 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.

Efficiency Issue #2: The importance of developing efficiency incentives without creating incentives to lower quality care.

In addition to structuring their basic reimbursement systems in ways to encourage efficiency, states have attempted to incentivize efficiency through the use of additional payments to facilities who keep their costs below the mandated ceiling. These payments are structured so that when a facility’s projected costs are below the ceiling that facility will receive a percentage of the difference between their cost and the ceiling. For example, in Georgia facilities receive 75 percent of the difference between their costs and the ceiling, while South Carolina allows up to 100 percent of the difference. The majority of states offering efficiency payments have not allowed them in the direct care cost centers. These efficiency payments can be beneficial both to facilities and the state. Individual facilities have the opportunity to make an extra profit by lowering costs while facilities in the aggregate have an incentive to lower costs which drives down the statewide median costs. While lowering costs can be beneficial to facilities and states, this cannot be accomplished by sacrificing quality and compromising the safety and comfort of residents. New York State currently does not have such incentives in place at this time, other than permitting facilities to make an additional profit by spending below the floor in both direct and indirect cost centers.

## RECOMMENDATIONS FOR EFFICIENCY ISSUE #2

- States should encourage spending in direct care areas by not permitting efficiency payments in their direct care cost component.
- Such efficiency payments should be considered in those non direct care areas less related to care.
- Any state with such incentives must have a program in place to formally evaluate, on an on-going basis, whether efficiency payments actually help lower costs without affecting quality or if they merely reward low-spending facilities.

Efficiency Issue # 3: The importance of developing creative incentives to encourage efficiency without encouraging a reduction in quality.

In addition to rate setting and efficiency payments, states have enacted a number of other initiatives to encourage efficiency. Some have set minimum occupancy levels when calculating rates in order to encourage facilities to have a level of occupancy the state has deemed necessary for efficient operation. These levels vary by state and reflect each state's determinations as to what is an efficient occupancy level. Thus, Mississippi sets its minimum occupancy rate at 80%, while South Carolina's is set at 96 percent. Some studies have indicated that higher occupancy leads to more efficiency.<sup>35</sup> Another approach has been to limit the proportion of certain costs to the total reimbursement rate. Thus, Pennsylvania limits administrative costs to 12 percent of a facility's costs. States have also begun to consider how they can not only encourage efficiency in the present, but also how they can incentivize actions which will lower costs for years to come. For example, Maine allows depreciation of certain energy efficient improvements to the facility. Vermont gives adjustments to rates for installation of conservation devices.

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<sup>35</sup> Ozcan, Y.A., Wogen, S.E., and Li Wen Mau. Efficiency Evaluation of Skilled Nursing Facilities, *Journal of Medical Systems*, Volume 22, Number 4/August, 1998.

### Efficiency Recommendation # 3

- 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 dedicate resources to make sure that formal evaluations are carried out for as long as the incentive is in place.

### Specific Recommendations for New York State

- The state should 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 formal method of evaluating the success of any initiative developed.



# APPENDICES

## ADVISORY COMMITTEE

LTCCC would like to thank the following members of the Advisory Committee who provided valuable input and expertise throughout the course of the research. Note that the findings and recommendations contained in this report are wholly those of LTCCC.

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### Detailed Chart of States' Reimbursement Systems<sup>1</sup>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components<sup>2</sup></b>	<b>Incentives<sup>3</sup></b>
<b>New York (Current System)</b>	638 Facilities 108,749 Residents 72% Medicaid Residents	RUGs II 16 Groups	<b>Direct Care</b> <b>Indirect Care</b> <b>Capital</b> <b>Non-Comparable</b>	<p><b>Access Incentives:</b> Add-ons for Special Care Units like AIDS, Traumatic Brain Injury, Ventilator Dependent, Pediatrics and Neuro-Behavioral. Has programmatic requirements.</p> <p>Add-on for residents with dementia who fall into certain clinically complex, behavioral, and reduced physical functioning RUGs categories.</p> <p><b>Quality Incentives:</b> Dementia Grant program to improve provider knowledge and experience and resident quality of care.</p> <p>Add-on for demonstrated costs associated with criminal background checks on non-licensed employees.</p> <p>Pay for Performance funds - not approved by CMS yet.</p> <p>CMP funds used to improve care and life.</p>

<sup>1</sup> 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 states, interviews with state officials. This information is accurate to the best of our ability.

<sup>2</sup> Cost Components – Areas into which expenses are grouped. Where Fair Rental is used, it is noted.

<sup>3</sup> Incentives – parts of the system that influence provider behavior. Access- encourages admittance of particular residents; Quality – encourages quality care; Efficiency-Encourages facilities to lower costs.

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
New York (Current System) continued				<p><b>Efficiency Incentives:</b>  Direct Care Ceiling<sup>4</sup>:105% of statewide mean price  Direct Care Floor: 90% of statewide mean price</p> <p>Indirect Care Ceiling:105% of peer group wide mean price  Indirect Care Floor: 92.5% of peer group wide mean price</p>
New York (2006 Legislation Not Implemented)		RUGs III 53 Groups	<p><b>Direct Care</b>  <b>Indirect Care</b>  <b>Capital</b>  <b>Non-Comparable</b></p>	<p><b>Access Incentives:</b>  Add-on for early dementia residents (\$8 per day), and bariatric residents (\$17 per day) - no programmatic requirements.</p> <p><b>Quality Incentives:</b>  Additional reimbursement from reform must be used for quality improvement. Must spend at least 75% of funds with 65% going to recruitment and retention of direct care workers.</p> <p><b>Efficiency Incentives:</b>  Direct Care ceiling: 114% of peer group wide mean price  Direct Care floor: 88% of peer group wide mean price  Indirect Care ceiling: 110% of peer group wide median price  Indirect Care floor: 88% of peer group wide median price</p>

<sup>4</sup> How ceilings are set can affect spending. Setting direct care cost ceilings higher than in-direct, encourages more spending in direct care and can be seen as a quality incentive.

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
New York (Proposed 2009-2010 Governor's Executive Budget)		RUGs III 53 Groups	Direct Care Indirect Care Capital Non-Comparable	<p><b>Access Incentive</b> Add-ons for special needs residents such as bariatric and dementia residents.</p> <p><b>Access and Efficiency Incentive:</b> State will reduce per diem rates by 25% over next four years for residents with lower acuity needs. This is to encourage placement of people who can safely be cared for outside of a nursing home in a less restrictive setting.</p> <p><b>Quality Incentive:</b> State will create a dedicated funding stream of \$50 million in the first year to reward facilities who perform well in staffing, quality indicators, and inspection surveys. A pool of \$125 million in the second year will be made available to high performing facilities and those who show great improvement from the previous year. To encourage nurse recruitment a fund for education loan repayment will be created.</p> <p><b>Efficiency Incentive:</b> Facilities within regional peer groups to be paid the median costs for facilities in that region - removal of ceilings and floors.</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Arizona</b>	124 Facilities 11,244 Residents 61% Medicaid Residents	4 Groups 3 are based upon ADLs and one is for ventilator dependent and specialty care. Uses the MD Time and Motion Study (See MD below)	<b>Primary Care</b> <b>Indirect Care</b> <b>Capital</b>	<b>Efficiency Incentives:</b> Indirect care component reimbursed at a single statewide rate that does not vary by resident level of care or geographic area.  Capital component reimbursed at a single statewide rate that does not vary by resident level of care or geographic area.
<b>Colorado</b>	209 Facilities 16,516 Residents 58% Medicaid Residents	RUGs III 34 Groups Index Maximizing <sup>5</sup>	<b>Health Care</b> <b>Food Costs</b> <b>Administrative Costs</b> <b>Property Costs</b> <b>Room and Board</b> <b>Capital</b> <b>Leasehold</b>	<b>Efficiency Incentives:</b> If projected Administrative; Property; or Room and Board Costs are less than the ceiling, the facility may earn an efficiency allowance of 12.5% of the difference in costs for Class I facilities (general skilled nursing) and 25% for Class II and IV facilities (specialized care programs).  Health Care and Food Costs Ceiling: 125% of weighted average of facilities in same peer group.  Administrative; Property; and Room and Board Costs Ceiling: 120% of weighted average of facilities in same peer group.

<sup>5</sup> Index maximizing-Placing the resident in the highest group he qualifies for.

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
Delaware <sup>6</sup>	44 Facilities 3,908 Residents 58% Medicaid Residents		<b>Primary Care</b> <b>Secondary Care</b> <b>Support</b> <b>Administration</b> <b>Capital</b>	<p><b>Access Incentives:</b> Residents receiving an active rehabilitative/preventive program as defined and approved by the State are reimbursed an additional 20% of the Primary Care component. To be considered for the program, a facility must develop and prepare an individual rehabilitative/preventive care plan.</p> <p>Residents exhibiting disruptive psychosocial behaviors on a regular basis as defined and classified by the State receive an additional 10% of the Primary Care rate component for additional nursing staff intervention. Facilities must have complete documentation of frequency of such behaviors in a resident's chart. These residents who receive an active psychosocial/preventive program shall be reimbursed an additional 10% of the Primary Care rate component. The care plan must indicate specific patient goals, and must have a physician's approval.</p> <p><b>Quality Incentive</b> Providers are reimbursed for agency nurse costs only to the extent their use of agency nurses does not exceed the allowable agency nurse cap determined each year by the State.</p> <p><b>Efficiency Incentives:</b> For the Support component, facilities which maintain costs below the ceiling are entitled to an incentive payment of 25% of the difference between the facility's cost and the ceiling, up to a maximum incentive of 5 percent of the ceiling amount.</p>

<sup>6</sup> Delaware system is in draft form as of November 18, 2008.

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Delaware</b>				<p>For Administrative component the incentive payment is set at 50% of the difference up to 10% of the ceiling amount.</p> <p>Minimum occupancy level of 90% is used in calculating rates.            Secondary Care Ceiling: 115% of median cost within peer groups.            Support Service Ceiling: 110% of median cost within peer group.            Administrative Ceiling: 105% of median cost within peer group.            Capital costs within peer groups: Are arrayed, Floor set at the 20th percentile and Ceiling at the 80<sup>th</sup> percentile.            Primary Care: Determined by multiplying the case mix resident classification system's nursing time factors by the 75th percentile nurse wage in each provider group.</p>
<b>Georgia</b>	346 Facilities 33,982 Residents 74% Medicaid Residents	RUGs III 34 Groups	<b>Routine and Special Services Dietary Laundry and Housekeeping, and Operation and Maintenance of Plant Administrative and General Property and Related</b>	<p><b>Access Incentive:</b> State gives facilities an add-on for residents with moderately to severe cognitive impairment.</p> <p><b>Quality Incentives:</b> Quality Improvement Initiative Program- Facilities must enroll and cannot qualify if placed on CMS special focus list.</p> <p>Four Incentives:            1) If a facility meets minimum staffing requirements it receives a 1% adjustment of allowable per diem for Routine and Special Services added to rate.            2) Adjustment to Routine and Special Services based on % of residents whose Cognitive Performance Scale scores from MDS are moderately severe to severe (facilities with 20-30% of these residents receive a 1% adjustment, 30-45% receive a 2.5% adjustment, and over 45% receive a 4.5% adjustment).            3) State pays required resident day fees for enrolled facilities.</p>



	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
Georgia Continued				<p>4) 1% adjustment to Routine and Special Services if facility earns 3 "points" by exceeding the statewide average in areas such as retention of staff, responses to satisfaction surveys, percentage of residents with pressure sores, restraints, or severe pain.</p> <p><b>Efficiency Incentives:</b>  Facilities are grouped by like characteristics and arrayed from lowest to highest per diem. A maximum percentile is used as a multiplier to define ceilings.  Laundry and Housekeeping, and Operation and Maintenance of Plant: maximum percentile is 90th.  Routine and Special Services: maximum percentile is 90th.  Dietary: maximum percentile is 60th for hospital based and 90th for free-standing.  Facility can earn 75% of difference between the ceiling and its projected costs up to a maximum per diem amount for each cost center. The ceiling for Administration and General costs is 105% of the peer group median.</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Idaho</b>	70 Facilities 4,142 Residents 59% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care</b> <b>Indirect Care</b>	<p><b>Access Incentives:</b> State gives an add-on to the per diem rate for: 1) Special Care Units such as Behavioral unit or Traumatic Brain Injury unit. 2) Equipment and non-therapy supplies not adequately covered by RUGs system, as determined by state. 3) Ventilator dependent residents and residents receiving tracheostomy care. 4) Residents not residing in a Special Care Unit, needing one-to-one staffing ratio. 5) Varying levels of one-to-one care.</p> <p><b>Quality Incentives:</b> State agency can award a quality incentive to facilities recognized for providing quality care to residents.</p> <p><b>Efficiency Incentives:</b> State gives an efficiency allowance to facilities whose projected Indirect costs are less than the ceiling in the amount of 70% of the difference between the cost and the ceiling, subject to fund availability.</p>
<b>Illinois</b>	787 Facilities 76,065 Residents 63% Medicaid Residents	RUGs III 34 Groups	<b>Nursing Support</b> <b>Capital</b>	<p><b>Access/Quality Incentives:</b> A number of add-ons for (51), among others, restorative care (i.e. bed mobility, walking, dressing etc); bladder retraining; psychotropic medication monitoring; dementia care unit; ventilator care; morbid obesity; pressure ulcer management; pain management and restraint-free care. In order to receive these add-ons, providers must document care.</p>

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
<b>Indiana</b>	502 Facilities 39,015 Residents 62% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care</b> <b>Indirect Care</b> <b>Administrative</b> <b>Capital:</b> Fair Rental System	<b>Access Incentives:</b> Add-on for residents in a Dementia or Alzheimer's Special Care unit. Add-on for facility with more than 8 Ventilator dependent residents.  <b>Quality Incentives:</b> State increases reimbursement for facilities, based on the Nursing Facility report card scores developed by the Indiana Department of Health.
<b>Iowa</b>	430 Facilities 24,388 Residents 48% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Patient Care</b> <b>Patient Care</b> <b>Services</b> <b>Support</b> <b>Administrative</b> <b>Environmental</b> <b>Services</b> <b>Property</b> <b>Other</b>	<b>Quality Incentives:</b> State gives additional reimbursement for Accountability Measures. Facility will receive this payment if they score at least 3 out of a total of 11 points based on performance on surveys, number of nursing hours, resident satisfaction scores, resident advocacy committee resolution rates, employee retention rates, maintenance of occupancy above 95%, presence of Chronic Confusion or Dementia units, and the low use of contracted nursing. Facilities who construct, replace, or renovate capital assets for the purpose of correcting safety code violations may receive capital rate relief for up to 2 years for costs incurred.  <b>Efficiency Incentives:</b> Facilities can receive up to 65% of the amount their non-direct care costs are below the state median.

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
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<p><b>Kansas</b></p>	<p>331 Facilities 18,588 Residents 53% Medicaid Residents</p>	<p>RUGs III 34 Groups Index Maximizing</p>	<p><b>Direct Care Indirect Care Operating</b></p>	<p><b>Access Incentives:</b> State gives facilities an add-on for ventilator dependent residents and removes these residents' CMI scores from the average CMI calculation to prevent double payment for eligible residents' care needs.</p> <p><b>Quality Incentives:</b> State administers a wage pass through program to employees providing direct care and support services to residents.</p> <p><b>Efficiency and Quality Incentives:</b> The state pays a per diem add-on ranging between \$0-\$3 based on measured outcomes in 5 areas: 1) case-mix adjusted staffing ratio 2) operating expense 3) staff turn-over rate 4) staff retention rate 5) occupancy rate.</p> <p><b>Efficiency Incentives:</b> Direct Care Ceiling: 120% of statewide median cost Indirect Care Ceiling: 115% of statewide median cost Operating Ceiling: 110% of statewide median cost</p>
<p><b>Kentucky</b></p>	<p>288 Facilities 22,936 Residents 53% Medicaid Residents</p>	<p>RUGs III 34 Groups Index Maximizing</p>	<p><b>Case-Mix Adjustable Portion of Standard Price Non-Case-Mix Adjustable Portion of Standard Price Non-Capital Facility Related Capital</b></p>	<p><b>Access Incentives:</b> Rather than paying median rate, state pays historical costs for facilities with 1) certified brain injury unit 2) distinct part ventilator unit 3) who are designated as institution for mental disease 4) who are a dually licensed pediatric facility 5) who are intermediate care facility for individuals with mental retardation or developmental disability.</p> <p><b>Efficiency Incentive:</b> Facilities are reimbursed at the statewide median rate.</p>
	<p><b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b></p>	<p><b>Case-Mix System</b></p>	<p><b>Cost Components</b></p>	<p><b>Incentives</b></p>

<b>Louisiana</b>	282 Facilities 25,787 Residents 74% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care Care Related Administrative and Operating Capital:</b> Fair Rental System <b>Pass-Through</b>	<b>Quality Incentives:</b> A minimum spending floor is set for Direct Care and Care Related costs at 94% of the statewide median price. Any facility who spends less than this floor must reimburse Medicaid for the difference between their spending and the floor. Add-on for facilities who convert a semi-private room to a private room for use by a Medicaid resident.  <b>Efficiency Incentive:</b> Facilities are reimbursed at 107.5% of statewide median rate for Administrative and Operating costs and 110% for Direct Care and Care Related.
<b>Maine</b>	108 Facilities 6,349 Residents 66% Medicaid Residents	RUGs III 44 Groups Index Maximizing	<b>Direct Routine Fixed</b>	<b>Access Incentives:</b> Different rates are given for intensive rehabilitation services for brain-injured residents. In order to receive these higher rates, the facility must meet a number of programmatic requirements relating to staffing and physical design and services must be given in a distinct part of a dual licensed facility. The state requires that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the brain injury unit from the Office of MaineCare Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Office of MaineCare Services authorizing such a change to its staffing pattern/reimbursement rate.

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
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<p><b>Maine continued</b></p>				<p><b>Quality Incentives:</b>          To assist facilities in maintaining minimum staffing ratios (Day shift: 1 direct care staff for 5 residents, Evening Shift: 1 direct care staff for 10 residents; and Night shift: 1 direct care staff for 15 residents), facilities not meeting the minimum ratios will have their base year allowable direct care cost component increased.          For the Routine cost component only, facilities that incur cost less than their prospective rate may retain any savings as long as it is used to cover Direct Care costs.</p> <p>Deficiency Rate - When a facility is found not to have provided the quality of service or level of care, required reimbursement is reduced to ninety percent (90%) of the provider's per diem rate, unless otherwise specified. This reduction in rate remains in effect until the deficiencies have been corrected.</p> <p>Funds have been appropriated to assist in recruiting and retaining staff. Funds are paid as add-on to the rates. The interim staff enhancement payments are adjusted at the time of audit. Any over or under payments is included as a part of the audit settlement.</p> <p><b>Efficiency Incentives:</b>          A ceiling is placed on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation.          Depreciation is permitted for a number of energy efficient improvements such as: Insulation; energy efficient windows or doors for the outside of the facility; including insulating shades and shutters; caulking or weather stripping for windows or doors for the outside of the facility; etc.</p>
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	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Maryland</b>	216 Facilities 23,092 Residents 61% Medicaid Residents	4 Groups Heavy Special Care, Heavy Care, Moderate Care and Light Care	<b>Nursing Service</b> <b>Other Patient Care</b> <b>Administrative and</b> <b>Routine</b> <b>Capital</b>	<p><b>Access and Quality Incentives:</b> State pays an enhanced rate for certain ancillary services for which it has deemed require nursing hours beyond state averages, to encourage access and promote quality care by providing reimbursement more in line with actual care resource needs. These ancillary services include decubitus ulcer care if ulcer is stage III or IV and was not the result of inadequate care; tube feeding, if it is the primary means of feeding; communicable disease care; central intravenous lines; ventilator care; and support services for ulcer care.</p> <p><b>Quality Incentives:</b> If a resident's condition improves so that they are classified in a lower group and the said resident had been at a prior (higher) classification for a minimum of 2 consecutive months, reimbursement is continued at the prior (higher) classification until discharge, transfer, return to prior (higher) classification, or after 2 months, whichever is less. The State has developed a Health Care Quality Account to improve the quality of care in the facilities. The account is funded by the civil money penalties paid by the facilities and the funds are used for establishment and operation of development project, grant award, relocation of residents in situation on crisis, provision of educational programs to facilities and any other purpose that directly improve the quality of care in facilities.</p>

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
Maryland continued				<p><b>Efficiency Incentives:</b>            If facility Administrative and Routine costs are below the ceiling, the facility receives 45% of the difference between its prospective cost and the ceiling up to a max of 10% of the ceiling cost.            For Other Patient Care costs a facility may receive 25% of the difference, up to 5% of the ceiling cost.            State sets ceilings for Administrative and Routine costs and Other Patient Care costs each fiscal year:            Administrative &amp; Routine ceiling: 112% of regional median            Other Patient Care ceiling: 118% of regional median</p>



	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Massachusetts</b>	428 Facilities 42,434 Residents 65% Medicaid Residents	6 Groups Representing range of management minutes	<b>Nursing</b> <b>Other Operating</b> <b>Capital</b>	<p><b>Access Incentives:</b> An add-on is paid to facilities which have over 75% of their residents with a primary diagnosis of Multiple Sclerosis. An add-on of \$3 per day is paid for residents with mental retardation and developmental disabilities in a facility that maintains clinical and administrative procedures.</p> <p><b>Efficiency and Quality Incentives:</b> An add-on is given to facilities which maintain 70% occupancy and have at least 188 beds. In addition, the facility must score above a specified threshold on a survey performance tool.</p> <p><b>Efficiency Incentives:</b> Nursing: Calculated by using the statewide flat rates for each of the six case-mix categories. Other Operating Cost: A flat rate of \$71.73 for all facilities</p>
<b>Minnesota</b>	388 Facilities 30,264 Residents 57% Medicaid Residents	RUGs III 34 Groups	<b>Nursing Services</b> <b>Other Care Related</b> <b>Services</b> <b>Other Operating</b> <b>External Fixed</b> <b>Property</b>	<p><b>Quality Incentives:</b> The State provides operating rate add-on to facilities in the years 2006 and 2007 based on certain indicators. In 2006 these were: 1) Quality indicators – 40% of score 2) Direct care staff turnover – 15% 3) Direct care staff retention – 25% 4) Temporary staff usage – 10% 5) Certification findings – 10% Facilities with scores between 40% and 100% received an add-on rate of 2.4% and average add-on amount of \$1.23. Facilities with scores below did not receive this add-on.</p>

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
Minnesota continued				<p>The indicators used in 2007 were:</p> <ol style="list-style-type: none"> <li>1) Quality of life – 20% (resident survey)</li> <li>2) Quality indicators -35%</li> <li>3) Direct care staffing level – 10%</li> <li>4) Direct care staff retention – 20%</li> <li>5) Temporary staff usage – 5%</li> <li>6) Certification findings – 10%</li> </ol> <p>Facilities with scores between 40% and 100% received an Operating rate add-on of 0.3% and average add-on amount of \$0.15 per day. Facilities with scores below 40% did not receive this add-on.</p> <p><b>Quality and Efficiency Incentives:</b>  For the years 2008 and 2009 the State awards payment for quality and efficiency efforts. This is a competitive process with facilities applying to the State with specific improvement projects. On further analysis the best efforts receive the funds. State's share in 2008 is \$1.2 million and \$6.7 million in 2009. Each facility has a report card which shows how the facility scored in 7 quality measures. Limits on certain cost categories will be determined based on these quality scores. The higher the facility's score, the higher its cost limits will be. Current state law requires this to go into effect once rebasing is phased in. Information on the report card is audited by the Nursing Facility Audits Unit.</p> <p><b>Efficiency Incentives:</b>  Facilities get to keep 50% of the difference (up to maximum of \$3 per resident per day) between the cost and the ceiling for each of the cost centers except the Direct Care cost center. Operating and Other Care Related Ceilings are calculated at 115% of the median cost within peer group.</p>

	Total #of SNFs, Residents, and % Medicaid Residents In State in 2007	Case-Mix System	Cost Components	Incentives
Mississippi	200 Facilities 36,696 Residents 77% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care</b> <b>Care Related</b> <b>Administrative and Operating</b> <b>Property:</b> Fair Rental System <b>Return on Equity</b>	<p><b>Access and Quality Incentives:</b> 37.2% adjustment to new bed value in calculating fair rental costs for licensed Alzheimer units. Higher Case Mix Weights for certain RUGs Groups if resident is in an Alzheimer Unit. The incentive is provided in the Direct Care and Care Related cost centers. It is only available to facilities whose case-mix adjusted Direct Care and Care Related costs are greater than or equal to 90% of the median for the cost report period being used to compute the base rate. The incentive will increase the Mississippi Base Weights used to compute the average case-mix score. This incentive will increase the base weight by 2%.</p> <p><b>Quality Incentives:</b> Facilities which received the floor cost for Direct Care and Care Related components must have increased their spending in these areas in order to avoid repaying the amount not spent on Direct Care and Care Related costs (This incentive was only applicable in Fiscal Years 1994 and 1995).</p> <p><b>Efficiency Incentives:</b> This incentive is provided for the Administrative and Operating cost center. If a facility's cost falls below the ceiling, then its Administrative and Operating rate is its trended cost plus 75% of the difference between the greater of the trended cost or the median and the ceiling. When calculating total patient days for a facility 80% will be set as the minimum occupancy rate to encourage occupancy levels the state deems most efficient. Direct Care and Care Related Ceiling: 120% of state median cost Direct Care and Care Related Floor: 90% of state median cost (only calculated in Fiscal Years 1994 and 1995) Administrative and Operating Ceiling: 109% of state median cost</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Montana</b>	85 Facilities 4,745 Residents 58% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Operating</b>	<p><b>Quality Incentive:</b> Add-on to rates to increase direct care worker wages.</p> <p><b>Efficiency Incentives:</b> Operating Component is set at 80% of the statewide price of nursing facility services for all facilities. Direct Costs component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is case-mix adjusted.</p>
<b>Nebraska</b>	208 Facilities 11,966 Residents 54% Medicaid Residents	19 Resident Classification Groups	<b>Direct Nursing Support Services Fixed</b>	<p><b>Access Incentives:</b> The State provides incentive to city or county owned facilities to take in Medicaid residents. Facilities with 40% or more Medicaid mix of inpatient days are eligible for this incentive. Facilities receive reimbursement for special needs residents (ventilator dependent, brain Injury, etc) only if they meet certain criteria such as having appropriately trained staff, having a distinct unit for special needs, and establishing admission and discharge plans for each class of special needs residents.</p> <p><b>Efficiency Incentives:</b> Direct Nursing Ceiling: 125% of median cost in peer group Support Services Ceiling: 115% of median cost in peer group Fixed Ceiling: set at a specified dollar amount</p>
<b>Nevada</b>	48 Facilities 4,737 Residents 58% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care Non-Direct Care</b>	<p><b>Efficiency Incentive:</b> Facilities are reimbursed at the statewide median rate.</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>New Hampshire</b>	81 Facilities 6,923 Residents 65% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Patient Care</b> <b>Other Support</b> <b>Administrative</b> <b>Plant Maintenance</b> <b>Capital</b>	<p><b>Access Incentives:</b> The State gives more money to facilities providing atypical care (brain/spinal injured residents, ventilator dependent residents). The rate calculation takes into consideration this extra care provided to residents.</p> <p><b>Efficiency Incentives:</b> The therapy costs included in Patient Care cost component are subject to a ceiling calculated based on the 85<sup>th</sup> percentile of the of statewide therapy portions of this cost component.</p> <p>Patient Care Ceiling: 100% of the statewide median costs. Administrative: Flat rate - the statewide median. Plant Maintenance: Flat rate - the statewide median. Other Support: Flat rate - the statewide median. Capital Ceiling: Facility costs arrayed and flat rate set at 85th percentile of costs.</p>
<b>New Jersey</b>	354 Facilities 44,459 Residents 63% Medicaid Residents		<b>Patient Care</b> <b>Raw Food</b> <b>General Services</b> <b>Property-Operating</b> <b>Property-Capital</b>	<p><b>Quality Incentive:</b> State has created a Nursing Home Quality of Care Improvement Fund to create a pool of money to be used in a grant program to be used by facilities to ensure quality care and promote staff recruitment and retention, increase staffing, and increase and improve patient care technologies</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>North Carolina</b>	414 Facilities 27,768 Residents 67% Medicaid Residents	RUGs III 34 Groups	<b>Direct Care Case-Mix Adjusted</b> <b>Direct Care Non-Case-Mix Adjusted</b> <b>Indirect Care</b>	<p><b>Access Incentive:</b> Specialized rate for head injury intensive rehab and ventilator dependent residents.</p> <p><b>Quality Incentives:</b> Add on for dietary costs related to religious needs of residents.</p> <p><b>Efficiency Incentives:</b> Efficiency Allowance in Direct Care Case-Mix Adjusted component equal to 50% of difference between the facility cost and the ceiling. Direct Care Case-Mix Adjusted Ceiling: Set at 110% of the statewide median cost Direct Non-Case Mix Adjusted Ceiling: Set at 110% of the statewide median cost Indirect Care: Cost set at 100% of the statewide median cost</p>
<b>North Dakota</b>	80 Facilities 5,774 Residents 55% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care</b> <b>Other Direct Care</b> <b>Indirect care</b> <b>Property</b>	<p><b>Access Incentives:</b> Specialized rates for Specialized Therapies, Total Parenteral Nutrition and Ventilator dependent residents. (Cost must be 2 1/4 times the actual Direct Care rate unless equipment is purchased by resident then it must be 1 3/4 times the rate). Onetime \$1,000 start up cost in first 30 days. Separate Rate for Traumatic Brain Injury residents.</p> <p><b>Efficiency Incentive:</b> Indirect Care: Cost set at 100% of the statewide median. All Cost Centers' Ceiling: Set at a specified dollar amount per diem rather than as a % of state median costs</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Ohio</b>	918 Facilities 77,751 Residents 63% Medicaid Residents	RUGs III 44 Groups Hierarchical <sup>7</sup>	<b>Direct Care Ancillary and Support Capital</b>	<b>Access Incentives:</b> Special rates for residents who are dependent on ventilators, or residents who have severe traumatic brain injury, end-stage Alzheimer's disease, or end-stage acquired immunodeficiency syndrome. <b>Quality Incentives:</b> One point is awarded for each of the following accountability measures the facility meets. The facility: had no health deficiencies on the facility's most recent standard survey; had no health deficiencies with a scope and severity level greater than E; resident satisfaction is above the statewide average; family satisfaction is above the statewide average; employee retention rate is above the average for the facility's peer group; occupancy rate is above the statewide average; Medicaid utilization rate is above the statewide average; case-mix score is above the statewide average. In addition, the number of hours the facility employs nurses is above the statewide average. Funds are distributed based upon the points.
<b>Oregon</b>			<b>Direct Care Direct Care Supplies Food Administrative and Other Services Other Operating Support Property</b>	<b>Access Incentive:</b> There is an add-on of 40% of the basic rate for complex medical needs residents. In order to be eligible, facilities must meet programmatic requirements. <b>Efficiency Incentive:</b> Allowable costs for all facilities are arrayed and the basic rate is set at the 63rd percentile

<sup>7</sup> Hierarchical - Placing the resident in the first group he qualifies for.

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Pennsylvania</b>	711 Facilities 79,422 Residents 63% Medicaid Residents	RUGs III 44 Groups	<b>Resident Care</b> <b>Other Resident Related</b> <b>Administrative</b> <b>Capital:</b> Fair Rental System	<p><b>Access Incentives:</b> The State gives an incentive payment to facilities with more than 80% Medicaid residents. The overall occupancy rate should be at least 90%. The level of incentive will be determined by the level of Medicaid occupancy above 80%. The greater the level of occupancy, the greater the payment to the facility.</p> <p><b>Quality Incentives:</b> State gives a Durable Medical Equipment (DME) grant to facilities to enhance the quality of life of the residents.</p> <p><b>Efficiency Incentives:</b> The state caps administrative cost at 12% of the total facility costs.</p> <p>Resident Care: Costs set at 117% of the median cost for facilities within the same peer group</p> <p>Other Resident Related: Costs set at 112% of the median cost for facilities within the same peer group</p> <p>Administrative: Costs set at 104% of the median cost for facilities within the same peer group</p>



	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>South Carolina</b>	169 Facilities 16,181 Residents 65% Medicaid Residents		<b>General Services</b> <b>Dietary</b> <b>Laundry, Maintenance &amp; Housekeeping:</b> <b>Administration, Medical Records &amp; Services</b> <b>Cost of Capital:</b> Fair Rental System	<p><b>Quality Incentives:</b> An add-on to the rate is given to provide an escort for Medicaid recipients receiving non- emergency transportation to a medical provider or health care professional for a medical service. This will cover one CNA for an 8 hour shift. Additional CNAs may be covered if needed.</p> <p><b>Efficiency Incentives:</b> If the facility's actual costs for three of the cost centers (General; Dietary; and Laundry, Housekeeping and Maintenance) are below the sum of these three cost standards, the facility is eligible for a cost incentive of an amount equal to the difference between the sum of these standards and the sum of the actual costs up to 7% of the sum of the standards. Profit is allowed if the facility's allowable cost is lower than the standard</p> <p>Administration, Medical Records &amp; Services up to 100% of the difference with the ceiling.</p> <p>A minimum occupancy rate of 96% is used to calculate rates.</p> <p>General Services; Dietary; Laundry, Maintenance &amp; Housekeeping Ceiling: Set at 105% of the mean statewide cost of each cost center. These cost ceilings are added and a facility is paid the lower of this aggregate cost ceiling or the sum of the projected allowable costs for these three cost centers.</p> <p>Administration, Medical Records &amp; Services Ceiling: 105% of the mean statewide cost</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>South Dakota</b>	106 Facilities 6,361 Residents 57% Medicaid Residents		<b>Direct Care</b> <b>Non-Direct Care</b> <b>Costs of Health and Sustenance</b> <b>Non-Direct Care</b> <b>Costs of Admin</b> <b>Capital</b>	<p><b>Access Incentives:</b> State pays add-on for rental cost of ventilator equipment for dependent residents. State pays up to \$25 per day for rental of pressure reduction overlay mattresses or low air loss beds.</p> <p><b>Quality Incentives:</b> State uses a point system to determine maximum salary of owner which awards a higher possible reimbursable salary for owners who have more experience in the health care field and who have higher levels of education.</p> <p><b>Efficiency Incentives:</b> Direct Care Ceiling: An initial ceiling is set at 115% of the statewide median cost, up to which 100% of costs are paid. A second ceiling is set at 125% of the statewide median cost, with costs falling within the 115-125% corridor being paid at 80% of the cost Non Direct Ceiling: An initial ceiling is set at 105%of the statewide median cost, up to which 100% of costs are paid. A second ceiling is set at 110% of the statewide median cost, with costs falling within the 105-110% corridor being paid at 80% of the cost</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Texas</b>	1149 Facilities 89,698 Residents 65% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Care Staff</b> <b>Other Recipient Care</b> <b>Dietary</b> <b>General/Administrative</b> <b>Fixed Capital Asset</b>	<p><b>Access Incentives:</b> Add on for ventilator dependent residents.</p> <p><b>Quality Incentives:</b> Performance Based Add-On Program. Facilities can earn additional reimbursement for compliance with state and federal regulations and on the basis of quality resident outcomes as measured by quality indicators. Quality Indicator scores for all facilities are indexed and the number of scores in the upper and lower 10th percentile are used to calculate facility payment.</p> <p><b>Quality Incentives:</b> The State offers an enhanced staffing program to encourage facilities to increase staffing/compensation to direct care staff. Facilities enroll in the program by committing to staff their facilities above the state average and/or compensate their workers above the state averages. Facilities are required to fill out annual staffing and compensation reports which reflect the activities of the facility while delivering contracted services from the first day of the rate year through the last day of the rate year. The state uses this report to determine compliance with the staffing requirements and recoupment amounts. These reports are subjected to audits by the state. Some are also field audited.</p> <p><b>Efficiency Incentives:</b> Cost Centers' Rate: Facilities are paid a flat rate based on either the median or mean statewide costs, depending on cost center.</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Utah</b>	84 Facilities 4,916 Residents 53% Medicaid Residents	RUGs III 34 Groups	<b>Nursing Operating Property:</b> Fair Rental System	<p><b>Quality Incentives:</b> The State provides an add-on rate for behaviorally complex residents when the assessment of the acuity and needs of the resident demonstrates that the facility is not adequately reimbursed by the RUGs score for that resident. The rate is added as a specific resident's payment and is not included in the calculation of the facility's case-mix rate. State Funds in the amount of \$1,000,000 are set aside annually to reimburse nursing facilities that have a quality improvement plan which includes the involvement of residents and family, a process of assessing and measuring that plan, quarterly customer satisfaction surveys conducted by an independent third party and have no violations that are at an "immediate jeopardy" level as determined by the State at the most recent re-certification survey and during the incentive period. Each year the state has targeted certain areas for a one time add-on for qualified facilities. For 2009 add-ons will be given for facilities which install enhanced nurse call systems, purchase at least one new patient lift system, and/or purchase a new side entry bath.</p> <p><b>Efficiency Incentives:</b> Operating: Costs reimbursed in a flat rate which is a fixed dollar amount and is the same for all facilities.</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Vermont</b>	38 Facilities 2,981 Residents 67% Medicaid Residents	RUGs III 44 Groups Index Maximizing	<b>Nursing Care Resident Care Indirect Director of Nursing Property and Related Ancillary</b>	<p><b>Access Incentives:</b> Facilities may receive an add-on for residents who have unique physical conditions which make it more difficult to provide care, subject to approval by the state.</p> <p><b>Quality Incentives:</b> Facilities may receive a quality reward based on performance in six criteria: number and level of deficiencies, no complaints on most recent survey relating to quality of care, quality of life, or residents rights, if facility is designated a Gold Star provider, resident satisfaction survey results above state average, fire safety deficiency score, and fiscal efficiency rankings based on allowable costs of facility.</p> <p><b>Efficiency Incentives:</b> State sets the minimum occupancy level for facilities (except those with 20 or fewer beds) at 90% when calculating the rate for Nursing Care and Ancillary costs. State gives an adjustment for costs related to installation of conservation devices or other efficiency measures.</p> <p>Nursing Care ceiling: Facilities allowable per diem costs per case mix point are arrayed and are capped at the 90th percentile Resident Care ceiling: 105% of statewide median Indirect ceiling: For hospital based facilities it is 137% of median statewide cost and for all other facilities it is 105% of statewide median</p>

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>Virginia</b>	268 Facilities 26,979 Residents 60% Medicaid Residents	RUGs III 34 Groups Index Maximizing	<b>Direct Patient Care Operating</b> <b>Indirect Patient Care Operating Plant</b>	<b>Access Incentives:</b> Add-on of \$10 for beds for residents with at least one stage IV pressure ulcer. Add-on for residents with Traumatic Brain injuries.
<b>Washington</b>	238 Facilities 18,824 Residents 60% Medicaid Residents	RUGs III 44 Groups Hierarchical Index Maximizing	<b>Direct Care</b> <b>Therapy Care</b> <b>Support Services</b> <b>Operations</b> <b>Property</b> <b>Financing</b> <b>Allowance</b> <b>Variable Return</b>	<b>Access Incentives:</b> The State is authorized to increase the Direct Care rate for residents who have unmet exceptional care needs. The State may establish criteria, patient categories and methods of exceptional care payment. The State may adopt rules and implement a system of exceptional care payments for Therapy Care such as for residents who are under age sixty-five, not eligible for Medicare, and can achieve significant progress in their functional status if provided with intensive Therapy Care services. Payments may be made only after approval of a rehabilitation plan of care for each resident and each resident's progress must be periodically monitored.  <b>Efficiency Incentives:</b> Rates in all cost centers are based on a minimum occupancy rate except for Direct Care. There is an add-on to the rate for capitalized improvements for all new or replacement building construction or major renovation projects. Support Services ceiling: 110% of median cost for facilities in peer group. Therapy Care ceiling: 110% of median cost for facilities in peer group Direct Care ceiling: 112% of median cost for facilities in peer group Operations ceiling: 100% of median cost for facilities in peer group

	<b>Total #of SNFs, Residents, and % Medicaid Residents In State in 2007</b>	<b>Case-Mix System</b>	<b>Cost Components</b>	<b>Incentives</b>
<b>West Virginia</b>	121 Facilities 9,031 Residents 72% Medicaid Residents	29 Case Mix categories based off of RUGs III categories	<b>Standard Services (Dietary, Laundry, Medical Records, and Admin)</b> <b>Mandated Services (Activities, Maintenance, Utilities, and Taxes and Insurance)</b> <b>Nursing Services</b> <b>Cost of Capital: Fair Rental System</b>	<b>Efficiency Incentives:</b> When calculating allowable costs per patient day a minimum occupancy level of 90% is used. If a facility has an occupancy level above 90% the actual level is used in the calculation. State gives an efficiency allowance to facilities whose projected Standard Services are less than the ceiling in the amount of 50% the difference between the facilities allowable Standard Services costs and the ceiling, not to exceed \$2 per patient day. A facility may be denied the efficiency allowance if it has any deficiencies during the reporting period.  Standard Services Ceiling: A ceiling is calculated for each sub-component (i.e. dietary) by finding the average cost for two bed groups (0-90 beds and 90+beds). The average cost for each sub-component is then added together and the sum is set as the ceiling for Standard Services costs Mandated Services Ceiling: Each sub-component cost (i.e. activities) is separated by bed groups (0-90 beds and 90+ beds) and arrayed from high to low. Costs in the 90th percentile are set as the ceiling for each sub-component and these ceiling costs are added together to calculate the total ceiling for Mandated Services costs

Foot notes will go here tomorrow

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