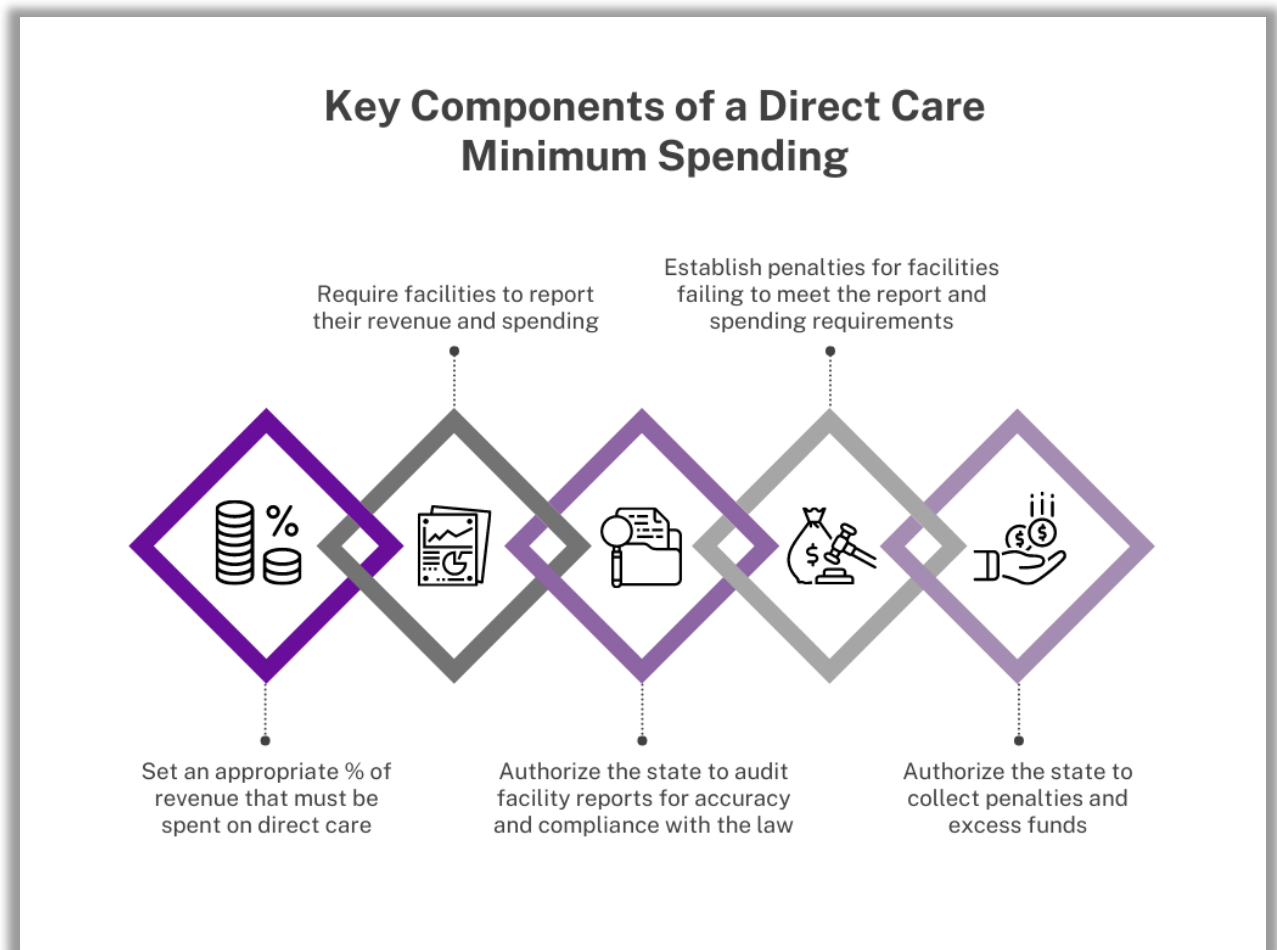


Key Components of a Direct Care Minimum Spending Law

The principal goal of a direct care minimum spending law is to ensure that nursing home providers spend the bulk of the funds they receive for the care of residents. To accomplish this goal, these laws generally:

- Set an appropriate percentage of revenue that must be spent on direct care,
- Require facilities to report their revenue and spending,
- Authorize the state to audit facility reports for accuracy and compliance with the law,
- Establish penalties for facilities failing to meet the report and spending requirements, and
- Authorize the state to collect penalties and excess funds.

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Calculating the percentage of revenue that facilities must spend appears to be the most challenging task lawmakers confront when drafting, passing, and implementing direct care minimum spending legislation. A major obstacle is how to define key terms.

Revenue

Failing to include a broad definition of “revenue” will thwart the principal goal of the law – to hold nursing facilities accountable for the full range of revenue sources that flow to them.

Recommendation: “Revenue” should include total operating revenue from all major revenue sources, including, but not limited to Medicaid, Medicare, private pay, Veterans Affairs, and long-term care insurance benefits. Limiting revenue sources to Medicaid reimbursement payments could encourage facilities to inappropriately utilize their non-Medicaid sources of revenue on non-resident-facing expenditures such as administrative fees and profits. It may also result in increased discrimination against Medicaid beneficiaries (since providers will have additional incentives to reject them as residents or inappropriately discharge them from the facility when their Medicare or other short-term benefits run out), thus exacerbating existing inequities in access to decent care for Medicaid beneficiaries.

Direct Care

A well-crafted definition of “direct care” can help ensure that revenue is spent largely for the benefit of residents.

Recommendation: The definition of what constitutes “direct care” should have at its foundation those expenditures related to the hands-on care provided by nursing personnel and other in-house staff who regularly interact with residents. Direct care expenses should also include ancillary services (pharmacy, housekeeping, food services, and activities) and support service (laundry, linen, dietary and social services). Most administrative costs (management and executive wages and benefits), capital costs, debt service, capital depreciation, rent and leases or fiscal services should not be considered “direct care.” To encourage nursing facilities to utilize permanent staff, which generally leads to better care for residents, legislative drafters should strongly consider discounting payments to outside contractors for nursing services. Payments to related parties where the value is greater than fair market value, and payments to employees who are not actively engaged in or providing services at the facility should be excluded as direct care expenditures.

Reporting Requirements

While most nursing homes are required to submit annual cost reports, these are unwieldy and not particularly suited to the direct care spending calculation. Direct care minimum spending legislation that requires specific annual disclosures and reporting responding to the exact provisions of the law will help regulators more effectively and efficiently ascertain compliance.

Recommendation: Each facility should be required to submit a report, and owners of multiple facilities should be required to submit a separate report for each facility. Each report should include a plain language summary description of the report, using a standardized form provided by a regulatory agency. The report and the summary should be posted and made readily available to the public by the nursing home and posted, in an electronic format, on a public-

facing website. The facility should be required to retain and provide to regulators and other government accountability agencies, upon request, all data and underlying supporting information used to make the report.

Audits

Information submitted by facilities must be evaluated on a regular basis to verify accuracy and ensure compliance with the law.

Recommendation: Every facility should be subject to auditing on a regular basis, with follow-up audits occurring as needed. In addition, a sample percentage of nursing homes should be audited annually. Certain circumstances, such as a reasonable possibility of fraud, should trigger an immediate audit of a facility. Facilities (along with their parent organizations, related parties, subcontractors, etc.) should be required to allow access and entry to their premises and records (including computer systems) by regulators (and other government accountability agencies) for the purposes of the audit. The results of audits should be made available in the facility and posted online for public access.

Penalties and Sanctions

Direct care spending laws require facilities to return excess revenue when they fail to meet the required spending percentage.

Recommendation: Legislation should require facilities found to have not met their required spending amount to return the excess revenue by a date certain. Repeated failures to comply with spending requirements should be met with enhanced sanctions, and greater scrutiny should be imposed on chains or owners/operators of multiple facilities that have repeated violations.

Collection of Penalties

Direct care spending legislation generally authorizes the state to recoup funds by withholding payments due to the facility and through deductions or offsets to prospective payments.

Recommendation: The state should be authorized to use legal action to recover amounts due and to refer cases of nonpayment to the state's debt collection agency. Information on penalties imposed and collected should be made publicly available.