South Dakota Legislative Research Council

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ANALYSIS OF NURSING HOME REIMBURSEMENT SYSTEM AND CONSTRUCTION MORATORIUM

Introduction

The nursing home industry in South Dakota receives the majority of its income from public funds and, in part because of this extensive governmental support, must comply with extensive state and federal regulation. The Medicaid program pays for the majority of nursing home care, and such care is one of the most expensive items in the state budget. In fiscal year 1997, nearly $34 million in general funds is budgeted to provide the state's match for federal Medicaid funds for nursing home care. Although nursing home patients are a small proportion of those eligible for Medicaid in South Dakota, they are responsible for a significant share of the expenditures; in FY97, nursing home patients are expected to account for only 7% of the eligible population while accounting for 30% of all Medicaid spending. Nationally, nursing home care consumes approximately a quarter of all Medicaid funds, so South Dakota spends a particularly disproportionate amount on these facilities.

Under the Medicaid program, each state develops its own system for reimbursing the costs of nursing home care. Because of the amount of resources devoted to nursing homes and questions about the appropriateness of these expenditures, several recent initiatives have aimed to decrease institutional populations and revise the formula for determining Medicaid payments to facilities. These proposals have been greeted with concern by the nursing home industry, because public funding provides so much of the support for nursing homes, and, thus, even minor changes in policy can have a significant impact on the financial condition of these facilities.

Nursing Home Bed Moratorium

Prior to FY89, a certificate of need process was in place for the expansion and construction of nursing homes. Under that system, new beds could be authorized in an existing facility or a new facility could be constructed if evidence presented to the Department of Health indicated that the beds were needed. The 1988 Legislature repealed the certificate of need process and instead instituted a moratorium on the expansion or construction of nursing homes. Supporters of the moratorium argued that the Medicaid program, which guarantees long-term care to individuals meeting eligibility requirements, had led to inappropriate growth in the number of nursing home beds, which had proved costly to the state. The legislation included a repeal of the moratorium after three years, which was designed to force the Legislature to revisit the issue and determine whether restrictions were still appropriate at that time.

Since its original passage, the moratorium has been renewed by legislative action in 1991, 1993, and 1995. The most recent legislation repeals the moratorium in 2000;

that five-year extension is the longest since the moratorium policy was established. When the extension was debated in 1995, the Department of Social Services argued that due to the impact of new programs which serve clients without placing them in institutions, the existing nursing home bed capacity in the state would be adequate into the next century.

Waivers

The Medicaid program, which was created by Congress in 1965, has been criticized for its institutional bias; because it originally provided coverage for nursing home care to all eligible individuals, while not covering less expensive services, nursing home populations, and the costs of the program, grew dramatically. At the same time, many of the clients being served by nursing homes did not need such an extensive, and expensive, level of care. This bias in the Medicaid program has led to numerous attempts to limit the nursing home population, such as South Dakota's moratorium.

The federal government acted to address the institutional bias in 1981 when it authorized Home and Community Based Services (HCBS) waivers under Medicaid. Under these waivers, states can extend Medicaid eligibility to non-institutionalized individuals who would be eligible for nursing home care, in order to provide them with a variety of more cost-effective and appropriate services in their homes and in community facilities. This waiver program obviously addressed a perceived need, as all fifty states now operate these programs.

In FY97, the office of Adult Services and Aging (ASA) expects to spend nearly $2 million to provide services to 625 clients under an HCBS waiver at a cost of approximately $3,200 per client. The cost of serving these clients is much less than the more than $21 thousand per year which will be paid to care for approximately 4,545 nursing home patients. Those being served under the waiver will receive a combination of home nursing visits, homemaker services, adult day care, and assisted living facility care. ASA also provides these and other home and community-based services to individuals who do not meet Medicaid eligibility requirements, and thus cannot be served under the waiver, based on the belief that spending money to provide non-institutional services to a broad population will prevent inappropriate nursing home placements and reduce costs in the long run.

Nursing Home Classification

Nursing homes in South Dakota are required by federal and state regulation to provide specific services and to meet certain staffing requirements. State regulations place facilities meeting these requirements into one of three classifications which are currently in use. Hospital affiliated facilities make up one classification. The other two are Level 1 Urban facilities, which are in communities with more than 200 beds, and Level 1 Rural facilities, which are in communities with fewer than 200 beds. As of April of this year, 24 Hospital Affiliated facilities with 1,541 beds were licensed, as were 19 Level 1 Urban facilities with 2,233 beds and 69 Level 1 Rural facilities with 4,334 beds.

The classification of facilities is crucial to the Medicaid reimbursement system. Nursing home payments are limited to no more than a certain percentage of the average costs for facilities in the same class. In this way, the reimbursement system

recognizes that the cost of operating nursing homes in different circumstances varies, and it allows payments to fluctuate accordingly.

Reimbursement System

In 1989, the Department of Social Services began implementing a new Medicaid reimbursement system for nursing home care, which became effective statewide at the beginning of fiscal year 1993. Under the previous system, nursing homes were paid a daily rate based on the average cost of all care provided to patients in the previous year increased by an inflation rate and divided by the occupancy factor, which is 365 multiplied by the average number of occupied beds. Daily rates under this system were limited to no more than 110 percent of the average for facilities in the same classification. This system attempted to reimburse facilities for all of their costs, while imposing limits so that facilities could not benefit by operating inefficiently.

In the view of many in the nursing home industry, this system was flawed because it did not specifically account for the different costs imposed by patients with different needs. Thus, nursing homes which had a disproportionate number of higher need patients were penalized because their costs were limited to no more than 110 percent of the average for similar facilities even though the actual cost of caring for their patients may have exceeded the limited rate. In response, South Dakota, along with Kansas, Maine, Mississippi, New York, and Texas, joined a Health Care Financing Administration (HCFA) demonstration plan to develop Medicaid nursing home reimbursement systems which account for resident needs.

Under the demonstration plan, each state was to develop its own reimbursement system, while HCFA collected data from all participating states. In South Dakota, a system was developed whereby staff at each nursing home regularly assess the condition of each patient, including those not receiving care paid for by Medicaid or Medicare, and assign them to one of thirty-five categories based on their therapeutic needs. Each of these categories is assigned a case mix score ranging from 0.60 to 4.09, with a score of one representing average needs in terms of cost, while lower scores correspond to lower cost needs and higher scores correspond to higher cost needs. These case mix scores are factored into the revised Medicaid reimbursement system so that payments reflect the cost of caring for patients who require different levels of care.

Rather than calculating a single payment for each nursing home patient, the new reimbursement system actually calculates three different payments for each patient. Under this system, the Department of Social Services establishes a rate to pay for the cost of providing direct care, including nursing and therapy services; these rates are adjusted by case mix scores. In addition, rates are established for the cost of providing non-direct care, including administrative, operational and nutritional services, and for capital costs; these rates are not adjusted by case mix scores because these costs do not vary according to patients' therapeutic needs.

To calculate the rate paid for direct care, the Department of Social Services takes each facility's actual cost of providing direct care to patients from the previous year's cost report, increases that amount by an inflation factor and divides it by the occupancy factor; all of these steps are similar to the previous reimbursement system. The next step is to divide that number by the facility's average

case mix score from the previous year, which establishes the case mix adjusted direct care rate; this rate can be no higher than 125 percent of the average for other facilities in the same classification. The daily payment made to a facility for direct care of each patient is the case mix adjusted rate multiplied by the patient's case mix score. Thus, this portion of the payment for each patient varies according to the needs of that patient and the cost to the facility to address those needs.

The calculation of the rates paid for non-direct care is almost identical to the previous reimbursement system. The Department of Social Services takes each facility's actual cost of providing non-direct care to patients from the previous year's cost report, increases that by an inflation factor and divides it by the occupancy factor to establish a daily rate. This rate cannot exceed 110 percent of the average for facilities in the same classification. Capital cost rates are calculated similarly, but the limits vary by type of facility. Hospital-based nursing homes are limited to 110 percent of the average for those facilities, while other facilities are restricted to a specific dollar amount. Neither of these rates is adjusted according to individual patient needs; the rate for each facility for these costs is identical for all patients.

Under the new reimbursement system, the actual payment to each facility for each patient is the sum of the three payments described above. This system is more complex than the prior single rate system, but it allows for distinctions to be drawn between cost components and provides a payment which is more directly associated to the specific cost of caring for each patient. The appendix to this memo provides a step-by-step calculation of the Medicaid payment for care provided to a hypothetical patient, which is intended to help illustrate how the reimbursement formula actually functions.

Effects of Reimbursement System Changes

The biggest changes in the reimbursement system are the separation of costs into separate components and the recognition of the variance in the cost of providing therapeutic services to patients with different needs. In addition, the new system includes a couple of changes that are favorable to the nursing home industry. First, the limit for direct care costs is set at 125% of the costs of similar facilities, while the previous limit was 110% of all costs for similar facilities. This looser limit means that fewer facilities are receiving a reduced level of payment on direct care costs.

Another change affects the calculation of the occupancy factor. Prior to 1989, the occupancy factor was calculated using an occupancy rate no less than 95%, while under the current formula the occupancy factor is calculated with a rate equal to no less than 3% below the state-wide average. This adjustment can be quite favorable to nursing homes. For example, in the case of one hypothetical patient in a nursing home with 90% occupancy while the statewide average occupancy is 95%, the Medicaid payment to the nursing home is 3.2% higher under the new formula than under the previous formula.

In addition to providing modest relief to nursing homes falling short of the statewide occupancy rate, the current formula offers considerable protection to all nursing homes if the statewide occupancy rate falls. Since the limit in the reimbursement formula is based on the statewide occupancy rate, nursing homes will not be penalized if they stay within 3% of that rate. Thus, as

occupancy rates fall, the payment per patient will increase. In this way the current reimbursement formula protects the financial interests of nursing homes if occupancy rates are low, even though this policy may not represent the best investment of Medicaid funds.

Payment and Occupancy Data					
State Fiscal Year	Average Daily Medicaid Rate	Percent Change from Previous Year	Average Daily Private Pay Rate	Percent Change from Previous Year	Average Occupancy
1992	$55.95	****	$62.00	****	94.8%
1993	$60.00	7.2%	$64.19	3.5%	95.2%
1994	$64.37	7.3%	$68.03	5.9%	95.5%
1995	$68.89	7.0%	$77.09	13.3%	95.6%
1996	$73.86	7.2%	$81.94	6.3%	96.0%
1997	$74.26	0.5%	$86.33	5.4%	96.0%

Payment and Occupancy Trends

The table above illustrates recent trends in Medicaid payment rates, private payment rates, and occupancy rates. The occupancy rates for each year are those used in calculating Medicaid payments; this occupancy data comes from cost reports which are a year or more old. As the table shows, the occupancy rate used to compute Medicaid payments has been close to 95% over the last several years, which means that the change in the reimbursement formula to allow no penalty for occupancy rates within 3% of the statewide average has been helpful to those nursing homes below 95% occupancy.

The payment data in the table, which includes partial data for the current fiscal year, shows that Medicaid payments increased at a stable rate until the current fiscal year, while the increase in rates charged to private pay patients has been less smooth. Over the entire period, private pay rates have increased by 39.2% while Medicaid rates have increased by 32.7%. However, for the period from FY92 to FY96, prior to the very small Medicaid rate increase in the current fiscal year, both rates increased by approximately 32%. Put another way, private pay rates were 10.8% higher than Medicaid rates in FY92, and that gap increased only to 10.9% by FY96. In the current fiscal year, though, the gap is 16.3%.

Impact of Recent Legislative Actions

As the table indicates, the average Medicaid rate did not increase nearly as much in FY97 as it had in previous years. This occurred because the 1996 Legislature approved the Governor's proposal to limit the growth in Medicaid nursing home payments. In practice, the Department of Social Services

is calculating FY97 payments using the same cost reports as FY96, and the occupancy rate and inflation factors date back to that time period as well. Thus, changes in case mix are the only significant cause of higher Medicaid payments in FY97. As nursing homes care for a population of patients with greater needs, which is the intent of the move to home and community based services, the average case mix score increases. Since the payment formula takes this into account, the average Medicaid rate in FY97 is expected to increase, but by less than a dollar per day.

The limitation in Medicaid rates could lead to a considerable increase in private pay rates as nursing homes attempt to recover more of their costs from other patients; however, the limited data for FY97 does not show this occurring yet. An increase in private pay rates would have a boomerang effect on the Medicaid program, because higher private pay rates would cause patients to deplete their resources and become eligible for Medicaid more quickly. If more nursing home patients receive care paid for by Medicaid, the savings from limiting Medicaid rates will be diluted.

The limitation on Medicaid payments to nursing homes could also have ramifications under a federal law known as the Boren Amendment. That law requires states to establish rates which are adequate to cover the costs incurred by efficiently operated facilities. If Medicaid rates are not increased in future years and the gap between them and private pay rates expands, the chances increase that the nursing home industry will pursue legal action on the grounds that the Medicaid rates do not allow them to operate efficient facilities. On the other hand, Congress has been discussing the repeal of the Boren Amendment, which could eliminate concern about legal action over rates depending on what regulation, if any, replaces the Boren Amendment.

The 1996 Legislature also considered HB 1225, which would have allowed a moratorium exemption for the construction of nursing home beds in privately-funded continuing care retirement communities. These communities provide a variety of services, including apartments, assisted living, and nursing home care on one campus so that their residents may "age in place." The bill specifically prohibited nursing homes in these communities from participating in the Medicaid program, but the legislation failed in part because of concern that expanding the total number of nursing home beds could potentially increase the costs of the Medicaid program. The greatest risk to the state from a moratorium exemption for these communities is that some of them might be unable to afford to provide lifelong nursing home care for their patients, in which case those patients might be transferred to facilities that accept Medicaid funding.

It is likely that the moratorium policy will continue to be a cause of controversy and lead to further legislative proposals along the lines of HB 1225. A policy allowing or mandating the transfer of beds between facilities might alleviate some of the concern, but that issue has been studied on multiple occasions since the imposition of the moratorium with no legislation having ever been introduced. Under the current moratorium and reimbursement policies, existing facilities have an exclusive legal right to a certain number of nursing home beds for which they will receive increasing Medicaid payments per patient if the statewide occupancy rate drops. Thus, one side effect of current policy is that it protects

existing facilities to such an extent that there is little incentive for competition or innovation.

Conclusion

Because of the large number of public dollars involved, Medicaid payments to nursing homes are likely to be controversial for the foreseeable future. The desire of the Legislature to save money, and the competing desire of the industry to recover the full cost of caring for Medicaid patients, who are the majority of all patients, virtually guarantees some level of conflict. In addition, changes in the health care industry make it probable that various aspects of nursing home regulation, including the moratorium, will need to be reevaluated and revised. The automatic repeal included in all of the moratorium legislation implicitly acknowledges this point. Providing long-term care to an increasingly elderly population is a difficult and expensive task, and nursing homes and the Medicaid program will almost certainly continue to be significant aspects of the service delivery system. Determining the appropriate role for these institutions is a significant challenge facing state and federal legislators as they design programs to meet the needs of the elderly.

This issue memorandum was written by Jeff Bostic, Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.

Appendix

Example of Nursing Home Payment

Medicaid payment in FY97 for 30 days of care for patient with a case mix score of 1.04 in a hospital affiliated facility with 100 beds.

1.	Audited 1994 Direct Care costs		$900,000
2.	Inflation Factor (7.5%)		$67,500
3.	Inflated Direct Care Costs		$967,500
4.	Occupancy Rate	92.5%	
5.	Occupancy Rate Limit (3% below state average)	**93.0%**	
6.	Occupancy Factor (365 X # of beds X higher of lines 4 & 5)		33,945
7.	Direct Care Costs per Day (line 3 / line 6)		$28.50
8.	Average Case Mix Score for Facility in 1995		0.96
9.	Case Mix Adjusted Rate (line 7 / line 8)	**$29.69**	
10.	Limit for Case Mix Adjusted Rate (125% of average for facilities in same class)	$36.50	
11.	Case Mix Adjusted Direct Care Rate (lower of lines 9 and 10)		$29.69
12.	Direct Care Payment (days X patient case mix score X line 11)		**$926.33**
13.	Audited 1994 Non-Direct Care Costs		$900,000
14.	Inflation Factor (7.5%)		$67,500
15.	Inflated Non-Direct Care Costs		$967,500
16.	Non-Direct Care Costs per Day (line 15 / line 6)	$28.50	
17.	Limit for Non-Direct Care Costs per Day (110% of average for facilities in same class)	**$28.25**	
18.	Non-Direct Care Rate (lower of lines 16 and 17)		$28.25

19. Non-Direct Care Payment (days X line 18)		**$847.50**
20. Audited 1994 Capital Costs		$100,000
21. Capital Costs per Day (line 20 / line 6)	**$2.95**	
22. Limit for Capital Costs per Day (110% of average for facilities in same class)	$3.50	
23. Capital Cost Rate (lower of line 21 and 22)		$2.95
24. Capital Cost Payment (days X line 23)		**$88.50**
25. Total Payment (line 12 +line 19 + line 24)		**$1,862.33**