



RIAFSA
Rhode Island Association of Facilities and
Services for the Aging

**RIAFSA Comments on Proposed Amendment to DHS State Plan Regarding Proposed Rate
Setting for Nursing Facility Services
December 18th 2009**

RIAFSA, like others, have advocated for an acuity adjustment to better reflect the increasingly sick and frail elders that will receive care in a nursing home. It is appropriate to develop a methodology to factor in the increase in resources that will need to be provided, particularly staff time, in order to meet residents' needs with dignity, comply with regulatory requirements, and continue with culture change initiatives.

Unfortunately, RIAFSA believes that the methodology proposed in Section 5 of the Method of Determining Individual Prospective Rates under the Principles of Reimbursement is deeply flawed and should be deleted from the Principles.

Specifically, the formula outlined in Section 5 b. i-iii to establish the prospective per diem rate will fundamentally change the current Principles of Reimbursement by shifting the per diem rate from one based on a provider's allowable, audited cost of providing care, up to a ceiling, to a system based on an average price for care. The current cost-based system both sets a limit on direct care costs that are reimbursed, which encourages efficiency and limits state spending, but also incentivizes homes to provide quality care by supporting higher levels of staffing. There is NO evidence that this current cost-based system is inefficient, or that homes are providing excess care, which will be demonstrated in these comments. The proposed system sets an average price for care, which is then adjusted for acuity.

This approach fails to target scarce Medicaid resources appropriately, is totally contrary to best practices, ignores current staffing guidelines, does not factor in regional costs of care, and will ultimately affect quality of care. This is not just a trade association making these comments, they are backed up by research and data, which are included in the Appendix.

Problem 1

The methodology developed for DHS establishes the average cost of care as the maximum 'price' for nursing care, which is based on an incorrect assumption that a nursing home's costs should deviate from the average only because of acuity. But, higher direct care expenditures, essentially more staff and longer tenured staff, are strongly associated with better quality, documented in study after study, including a CMS study mandated by Congress¹. So just paying a facility's direct care rates based on an average – with no evidence that costs above the average are due to inefficiency or excess care, penalizes homes for doing exactly what they are mandated to do – provide quality care.

Moreover, the concept of paying all facilities the same price, with only a small acuity adjustment, without regard for individual facility expenditures on care, has been shown to result in lower quality

of care², and, according to our experts has been rejected by virtually every other state. It basically creates strong incentives to reduce costs, in this case, nursing care costs.

Problem 2

The report indicates that many states use a form of acuity adjustment, but this approach developed for DHS is out of line with how other states apply it for nursing homes, which is an industry that is very dependent on staffing, as they provide high touch, low tech, care to frail individuals. Most states place cost control mechanisms on areas less directly related to patient care, while still correlating rates on the most important costs – those related to patient care – to facility costs of care. We have two comprehensive surveys of state Medicaid systems that prove this, as well as feedback from national experts on Medicaid payment policies. Quite simply, the model that was developed for DHS is an aberration in how Medicaid pays for care.

- According to a GAO report³ on Medicaid Nursing Home Payments, **most states, in one form or another, encourage homes to target spending on resident care, by applying an acuity adjustor to each facility's rate.** The DHS proposal does not do this.
- A report by the Office of Rates Management at the Washington Department of Social and Health Services⁴ surveyed case mix systems in over 20 states. While systems vary, virtually all states set their direct care rates with a cost-based approach, like RI currently does, which is then adjusted for acuity. But this proposal runs counter to that by setting one price for care, which is then adjusted for acuity.

Problem 3

The DHS proposal is not consistent with promoting proper incentives or efficiencies. Most states do not use a statewide average price because they could end up paying low-cost homes significantly in excess of their costs. This is not an effective allocation of resources. A provider with costs of care *below* the statewide average would be rewarded with an automatic upward adjustment to their rate, even before the acuity adjustor. Such an automatic adjustment does not appear to comply with the current Principles of Reimbursement, which reimburses providers based on documented, audited costs that are reported to the state. This methodology will incentivize homes to cut spending on nursing home care and pay lower cost homes in excess of their costs. What will they do with the money? It is not clear that it will go to patient care.

Conversely, it adversely affects providers who have consistently higher levels of staffing and longevity among staff, which as noted throughout this testimony is associated with higher quality of care. We should not penalize providers by automatically reducing their reimbursement to a statewide average, **EVEN BEFORE** the acuity adjustor is applied. The current system provides an (albeit limited) incentive to provide quality care through better staffing (both number of staff and staff retention), and applying a uniform rate on all providers eliminates this important factor.

Problem 4

There is an assumption in the report that some current staffing / acuity trends are inappropriate (e.g. some homes are overstaffed for their acuity), and that higher labor costs are unjustified, which is misguided at best for the following reasons:

- It is contrary to published guidelines on staffing and the reality of staffing rates in Rhode Island. The Centers for Medicare and Medicaid Services (CMS) established a MINIMUM staffing threshold of 4.10 hours of nursing care per day per nursing home resident⁵. Indeed, these estimates are used as part of its rating system for nursing homes. Yet according to data from the RI Department of Health⁶, only 8 out of the 85 homes for which they have data meet or exceed this number. Clearly nursing homes in Rhode Island are not overstaffed - regardless of their acuity score under this proposed system! Indeed, most homes are struggling to care for their residents by recruiting and retaining quality staff in the face of the budget cuts in recent years. The proposed methodology does not factor this at all, rather it would result in staffing cuts at many homes, and could promote higher staff turnover.
- It also ignores the fact that, despite being a small state, labor costs do vary from region to region. According to an accounting firm, the average cost per day by region of nursing home care varies from \$135.16 to \$153.84.

Problem 5

If this proposal goes through, many nursing homes will see an immediate and dramatic cut in their reimbursement, totaling hundreds of thousands of dollars. The cumulative effect of this methodology will be to drive the average rate lower each year, starving nursing homes and reducing staff. In addition, the acuity adjustor will eliminate incentives for quality care by penalizing providers who, through culture change initiatives, staffing, and other measures seek to improve the health and functional status of their residents. If a resident improves and his or her acuity level decreases, due to the care received in a nursing home, the ultimate effect could be a reduction in a provider's acuity score, thereby reducing reimbursement. Again, many states have safeguards to support efforts to improve a resident's function, which are nonexistent here.

While this testimony focuses on the flaws of this proposed methodology and urges that it be scrapped, RIAFSA does stand ready to work with the Department of Human Services as they seek to develop a long term system to reimburse nursing home care, one that appropriately reflects acuity, incentivizes the provision of direct care, and promotes quality care and resident-centered culture change principles.

References

¹ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report to Congress: Phase 2 Final. Centers for Medicare and Medicaid Services. www.directcareclearinghouse.org/download/PhaseIIVolumeIofIII.pdf

² Chapin White "Medicare's Prospective Payment System for Skilled Nursing Facilities: Effects on Staffing and Quality of Care." Inquiry 42:351-366 (Winter 2005/2006)

³ General Accounting Office (GAO). "Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures." October 2003. <http://www.gao.gov/new.items/d04143.pdf>

⁴ Medicaid Nursing Facility Payment System Access, Quality of Care, and Quality of Life for Nursing Facility Residents: Interim Report of Findings and Discussion of Further Study." Office of Rates Management, Washington Department of Social and Health Services. October 2002.

⁵ Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes Report to Congress: Phase 2 Final. Centers for Medicare and Medicaid Services. [www.allhealth.org/BriefingMaterials/Abt-NurseStaffingRatios\(12-01\)-999.pdf](http://www.allhealth.org/BriefingMaterials/Abt-NurseStaffingRatios(12-01)-999.pdf)

⁶ RI Dept of Health, Health Services Regulation, Facilities Regulation. Nursing Facility 2008. Licensed Staffing Report.