NYAHSA | New York Association of Homes & Services for the Aging

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MEMORANDUM

TO: RHCF Members

FROM: Dan Heim, Vice President for Public Policy

DATE: March 6, 2009

SUBJECT: **Position Paper on Nursing Home Regional Pricing**

ROUTE TO: Administrator, Directors of Finance and Nursing

ABSTRACT: Reaction to regional pricing proposal in 2009-10 Executive Budget.

Introduction

NYAHSA is pleased to share with its members the attached report on the nursing home regional pricing proposal contained in the governor's 2009-10 Executive Budget. We collaborated on the paper with our Joint Association Task Force partners, the New York State Health Facilities Association (NYSHFA) and the Healthcare Association of New York State (HANYS).

We have shared this report with key legislative staff, and will be providing it to selected legislators, other associations and other parties over the next few days.

The Administration continues to aggressively push the Legislature to adopt this proposal, having briefed lawmakers and staff. They have also contacted a small number of individual facilities (including NYAHSA members) to discuss the proposal. NYAHSA staff met with the governor's office, the Department of Health and Division of the Budget last week to discuss our concerns with this proposal and others, and are tentatively scheduled to meet with them again early next week. We have had several meetings with individual legislators and key Senate and Assembly staff in recent days, and remain in close communication with our other association colleagues.

We will keep you updated on our progress. If you have any questions or comments on the attached report, please contact me at 518-449-2707, ext. 128, or by e-mail at dheim@nyahsa.org; or Ami Schnauber at ext. 121 or aschnauber@nyahsa.org.

Attachment

ANALYSIS OF THE PROPOSED NURSING HOME "VALUE BASED REGIONAL PRICING METHODOLOGY" IN THE EXECUTIVE BUDGET

Introduction

The New York Association of Homes and Services for the Aging (NYAHSA), New York State Health Facilities Association (NYSHFA) and Healthcare Association of New York State (HANYS), collectively representing approximately 90 percent of the nursing homes in New York State, has analyzed the proposed "value based regional pricing methodology" for nursing home services included in Governor Paterson's Executive Budget for state fiscal year (SFY) 2009-10. What follows is a synopsis of the reformed methodology already in place as well as our reactions to the regional pricing proposal.

Reimbursement Has Already Been Reformed

Comprehensive Medicaid reimbursement reforms enacted in the 2006-07 state budget recognized the need to address the outdated system in place since the mid-1980s, which had led to facility closures and desperate financial circumstances for the nursing home system of care. The reforms "rebased" (i.e., updated) the system's cost base year from 1983 to 2002, and changed the patient classification system to reflect the care needs of today's residents. This reformed system was carefully designed to:

- Focus on residents' needs
- Address hard-to-place individuals
- Promote cost-effective resident-centered care
- Preserve the service "safety net"
- Enhance quality of care
- Maintain an updated and rational rate-setting cost base
- Produce equitable payments more aligned with current costs
- Make payments more sensitive to current labor costs
- Include a predictable, orderly transition plan
- Streamline and simplify the previous system
- Include systemic cost-containment features

Included in the 2006-07 reimbursement reforms was a $3 million pay-for-performance demonstration intended to identify valid quality measures and reward top-performing facilities. A workgroup which included experts from the Department of Health (DOH), NYAHSA, NYSHFA and HANYS spent several months reviewing quality measures (QMs) appropriate for use in this demonstration. It was decided to use a risk adjusted pressure ulcer measure NYAHSA developed through a patient safety grant, and to build on that in future years with other validated risk adjusted measures. DOH indicates that payments under this demonstration are still awaiting approval from the federal Centers for Medicare & Medicaid Services (CMS). The reimbursement system enacted in 2006 was the by-product of over two years of careful work, open deliberations and financial modeling involving numerous stakeholders including nationally recognized reimbursement experts, clinicians, the provider community, the Legislature, the governor's office, DOH and the Division of the Budget. Since the law was

enacted, DOH and the provider community have worked closely to secure federal approval of the new system from CMS, analyze the Medicaid cost reports and build the rate setting infrastructure needed to produce the revised Medicaid rates.

Following a two-year phase-in for the state and providers to prepare for implementation, the new system was to become effective on January 1, 2009. However, the Deficit Reduction Plan (DRP) enacted in February 2009 delayed implementation until April 1, 2009.

Key Concerns on Value Based Regional Pricing Proposal

We have a number of concerns with this proposal, which are outlined below. Unless otherwise noted, our analysis utilizes the figures provided by DOH for the elimination of the current reform statute (i.e., "rebasing"), the imposition of regional pricing in its place, and the reduction of payments for low-acuity residents. Proposals for a transition fund, a quality pool and a reprogrammed financially disadvantaged facility pool are not reflected since they are time-limited and not guaranteed year-to-year to any facility.

PROCESS ISSUES

1. **It was developed without input from key stakeholders.** In contrast to the transparent reforms enacted in the 2006-07 state budget, this untested system was developed without engaging key stakeholders in a deliberative process. As a result, the potential real world implications of various elements of the system were not properly weighed and considered in its development. Some of these implications are discussed below.

2. **As a practical matter, it cannot be implemented during SFY 2009-10.** To implement a new system, the state would have to submit and receive approval from CMS to amend its Medicaid State Plan; develop, program and test the rate setting system; analyze and desk audit over 650 Medicaid cost reports; issue rates and address errors and omissions. This process will have taken three years to complete in the case of the system enacted in 2006. While this process could move more quickly under a regional pricing model, it is virtually inconceivable that the state would actually be paying Medicaid rates based on yet another new system in SFY 2009-10. Accordingly, any cash savings attributed to regional pricing in SFY 2009-10 are highly suspect.

3. **Facilities would be denied due process.** Medicaid rate appeals would only be processed if they relate to: (1) DOH errors or omissions of data in calculating the operating portion of rates; (2) the capital component of rates; and (3) any other reasons DOH deems appropriate. This would deny due process to facilities seeking to challenge other aspects of the rate calculations.

4. **We do not have confidence in the facility-specific impact estimates.** In at least one case, a facility was estimated to receive a $5.3 million benefit from regional pricing. DOH later confirmed that the estimated benefit was nearly 90 percent less, and has failed to substitute the corrected estimate in any follow-up impact listings provided to the Legislature and others. We have questions about other facilities' estimated impacts as well. Furthermore, we are still awaiting information from DOH needed to evaluate various elements of the proposal.

SUBSTANTIVE ISSUES WITH REGIONAL PRICING

1. **It would pay every facility in every region less than the average cost of providing services.** By definition, this will result in a majority of facilities being paid less than their actual, allowable costs of providing care. This does not even factor in the effect of Medicaid rate cuts that have already been taken or others that are proposed in the SFY 2009-10 Executive Budget. Indeed, a study by an independent national expert, BDO Siedman, indicates that even with rebasing, Medicaid payments will still be 4-5 percent below actual costs. Imposition of the proposed regional pricing system would further reduce these payments by nearly $180 million. It is illogical to conclude that reducing payment levels to less than the average cost of providing care will result in enhanced quality of care.

2. **It would place no limit on the costs that DOH could disallow in developing regional prices.** The language provides that the regional prices will be determined "…using allowable costs, as determined by the commissioner." This is a dangerous precedent, since it could lead to facility rate cuts that are far larger than have been estimated. As it is, the state's impact estimates reflect the elimination of nearly $325 million of facility operating costs that could otherwise be considered reimbursable.

3. **It would result in large revenue swings for individual facilities and entire regions.** Two-thirds of all facilities would see a revenue change greater than 5 percent of their total Medicaid revenues, and over 30 percent would see revenue swings of 10 percent or greater. With Medicaid accounting for 70 percent of all patient care revenues, these changes will significantly affect facilities' budgets.

   Revenues would also be significantly reduced and redistributed regionally. For example, Western New York would see a 9.2 percent decrease in funding, with 82 percent of facilities in that region experiencing cuts. New York City would see a 6.3 percent funding cut, with 59 percent of facilities negatively impacted.

4. **It would ignore legitimate cost differentials among facilities.** The underlying approach—"one-price-fits-all" within a region—assumes that nursing homes with costs above that regional price are inherently inefficient and can adjust within a short time. Nursing homes are simply not that one-dimensional in any area of the state, and the case-mix adjustment mechanism simply does not account for all of the differences. For example:

   - the state has acknowledged that publicly-sponsored nursing homes are faced with labor costs outside of their control, and cannot adjust to regional pricing. The state's response is that counties can take advantage of intergovernmental transfer (IGT) funding to make up for the inadequate rate, so long as the county puts up the non-federal share of Medicaid. IGTs have been scaled back in recent years, however, and there have been federal proposals to eliminate them entirely.
   - many of the largest nursing homes, those with 300 or more beds, have been identified as among the most severely hurt by regional pricing. These homes are typically high rise buildings in urban settings with costs above average because of some of those characteristics. Ignoring those differences and cutting payments cannot be addressed by modifying the facility's layout—cuts would have to come in staffing. This raises a major public policy question as to the state's commitment to ensuring access to nursing home care in metropolitan areas, particularly New York City.

- similarly, hospital-based nursing homes are required by government-imposed accounting rules to have costs allocated to them from an affiliated hospital that may cause them to have higher costs. Again, reductions in income could only be met by cuts to operations.
- facilities that staff higher, offer more private rooms, have more square footage per resident, and/or offer more activities have higher costs. Regional pricing will deny reimbursement for these costs, which enhance resident quality of life.

In every region, there is a wide range of nursing homes with characteristics that affect the cost of operation: urban, suburban and rural; large and small; public and non-public; unionized and non-unionized; and mix of chronic care and sub-acute services. The net result is variation in the operating cost per day in every region of the state, not all of which is able to be changed by management. One-price-fits-all financing—especially when it is applied to 70 percent of a facility's income—is too blunt an instrument to be imposed without adversely impacting services to Medicaid recipients in a significant proportion of nursing homes.

5. **It would do a poor job of adjusting payments for the single biggest driver of facility costs—labor.** Direct care staff (RNs, LPNs and aides) comprises 55 percent of all salaries and wages paid by nursing homes. In every region, homes that pay their direct care staff more than the regional median are much more likely to be hurt by regional pricing. Statewide, 72 percent of homes with nursing wages above their regional median would see reimbursement drop, while 65 percent of homes that pay below regional medians would receive increases.

6. **It would disproportionately impact facilities that are already experiencing losses.** Of the facilities that would lose under regional pricing, 55 percent are already experiencing operating losses. In fact, facilities that currently lose money on operations would see an average $8 per Medicaid day decrease, while the average facility with a positive margin would lose $0.29 per Medicaid day. Implementing such a system will tend to perpetuate these operating losses, and potentially lead to significant layoffs, facility insolvency, bankruptcies and/or closures.

7. **Payments would be cut dramatically for certain types of patients, leading to access problems.** The proposal would reduce reimbursement for hands-on care for patients in the two lowest scoring categories (i.e., PA1 and PB1) by 25 percent, phased-in over four years. The impact of this cut would go up dramatically over time and continue in the system. Furthermore, the payment for the lowest scoring patients may already be declining under the RUG-III patient classification system taking effect January 1, 2009 versus the payment level under the previous system. This cut is also based on the faulty premise that people in these categories can, by definition, be served in assisted living or other settings.

8. **It would create chaos in the delivery system.** As it is, facilities have spent many months preparing for implementation of the rebased system clinically, operationally and financially, only to see the system delayed by three months in the DRP enacted in February 2009. Under existing law, another major change will be hitting the system effective April 1, 2009—implementation of a Medicaid-only case-mix index (CMI). For over 20 years, nursing home reimbursement in New York has been based on the care needs of all patients in the facility, otherwise known as an "all-payor CMI." Besides cutting overall reimbursement by $300 million or more, this change could, along with regional pricing and related Executive Budget proposals, have dramatic effects on patient admissions, discharges, access to services and care delivery.

9. **It would discourage facility "rightsizing" and resident-centered projects.** The state's public policy is to encourage nursing homes to downsize their bed capacities; to diversify their services to include assisted living, adult day health care, home care and other community-based programs; and to move towards more resident-centered models of care. Rightsizing, diversification and resident-centered initiatives such as "greenhouses" improve quality, ultimately lead to systemic cost savings and help transform the system in ways that the state seeks to encourage.

   However, when a nursing home downsizes and offers more resident-centered options such as private rooms, simple economics dictate that its unit cost of operation will likely increase. A regional pricing system that pays every facility less than the average cost irrespective of these types of projects will impede these much-needed reforms. Furthermore, an organization that operates a nursing home facing huge losses from proposals like regional pricing must scramble just to meet payroll, and is even less likely to be able to make the upfront investments required for such projects.

10. **Not-for-profit facilities would be denied access to needed operating funds.** The proposal would also re-institute requirements for not-for-profit operators to deposit their Medicaid capital reimbursement into a segregated depreciation fund for capital expenditures. These requirements were dropped in the 2006 reforms because facilities were accumulating large balances in these accounts at the same time as they were cash-starved on the operating side and unable to timely pay their bills. Imposing these requirements again will needlessly create more cash flow problems for these facilities.

TRANSITION AND QUALITY FUNDING ISSUES

1. **While the proposal includes other funding streams, it cuts more than it invests, which will worsen over time.** Funding is provided for temporary transition payments, a quality incentive pool and added financially disadvantaged facility funding. However, the estimated cuts far exceed any benefits from these "investments." Moreover, the transition funding would run out over time, leaving the impacts, and the proposed quality pool and financially disadvantaged facility pool are time-limited. None of these funding sources is guaranteed year-to-year to any facility, since DOH has discretion over which facilities would benefit.

2. **Some of the most severely impacted facilities would be ineligible for transition funding.** Municipal and county-run facilities are ineligible for transition funds. In the aggregate, these facilities would lose over $100 million under regional pricing and, individually, 40 percent would experience reductions exceeding $2 million per facility.

3. **A major component of the plan, the quality pool, is based on seriously flawed measures.** We support quality incentives based on properly risk-adjusted quality measures and other criteria. While we do not know exactly how DOH arrived at their estimated funding distributions, we have serious concerns with the integrity of the metrics being used for staffing levels, DOH survey results and QMs. Faulty measures will inevitably lead to some number of high quality facilities being denied quality incentives and vice versa. Appendix A details our concerns in this regard.

Conclusion

If state lawmakers believe there is value in studying alternative pricing approaches or other potential reimbursement reforms, our Associations would be more than pleased to join the administration and the Legislature in such an effort. However, such a process should be deliberate, transparent, inclusive and sufficiently broad so as to assess the implications of reform across the long term care system as a whole.

Please contact Dan Heim at NYAHSA at (518) 449-2707, ext. 128 or dheim@nyahsa.org; Robert Murphy at NYSHFA at (518) 462-4800 or rmurphy@nyshfa.org; or Ray Sweeney at HANYS at (518) 431-7729 or rsweeney@hanys.org if you have any questions on this summary.

Appendix A

Evaluation of Nursing Home Quality Incentive Pool

Introduction

Part of the value based regional pricing methodology is a quality incentive pool. DOH would be authorized to pay up to $50 million in quality incentives to eligible nursing homes in SFY 2009-10, and $125 million in SFY 2010-11 based on a composite score based on staffing (20 percent); DOH survey results (20 percent); and long stay quality measures (60 percent).

In 2009-10, facilities with composite scores in the top 20 percent in their survey region would be allocated funds based on Medicaid days. In 2010-11, the highest scorers as well as those showing improvement would be allocated funding.

Staffing Measure

The staffing measure is based on the ratio of registered nursing (RN) time to total RN, licensed practical nurse (LPN) and certified nurse aide (CNA) time. The staffing time data are from the federal ASPEN database which houses form CMS-671 information submitted by states. CMS 671 is filled out by a facility at the time of the periodic inspection and reflects self-reported staffing data for the two-week period prior to the inspection.

The measure itself and the data from which it is derived are problematic from the following standpoints:

- The source data are from a two-week period, rather than a full-year measure of staffing such as the cost report. A two-week period may not be at all representative of ongoing staffing levels. For example, if the two-week period occurred during the major holidays, RN staffing would be lower than the usual because management staff is often on vacation.
- We question the use of the ratio of RN time as an indicator of quality, rather than total staff time. For example, the ratio will look worse for a facility that uses 2 RNs and 10 CNAs than another facility using 2 RNs and 5 CNAs—this is illogical. It would also penalize providers for staffing with more CNAs and LPNs, even though this may be entirely appropriate and lead to greater quality of care.
- The staffing measure fails to take into account each facility's case-mix, a measure of the care needs of its residents and a major determinant of staffing. For example, some types of residents (e.g., Alzheimer's, etc.) require less RN staffing and more CNA staffing, as their care needs are less skilled and more supportive. In this example, the RN ratio would penalize facilities serving relatively high numbers of these individuals.
- It may be more difficult to actually hire RNs in certain geographical areas despite facilities' best attempts to recruit these individuals.
- Staffing in other areas that could have a major bearing on quality are omitted from the measure including therapists, therapy aides and assistants, pastoral care, recreation therapy, housekeeping and social services.

DOH Survey Results

The survey measure is based on each facility's recertification survey score. The scores would be aggregated separately for each DOH regional area office due to major inconsistencies between survey regions.

Survey results are not a valid measure of quality due to significant variations in citations both within and between regions. DOH acknowledges the high degree of variation by calculating the survey score separately for each of the survey regions, rather than doing so on a statewide basis. In recent years, some regions have seen 13 percent of homes be deemed deficiency free, while in other regions the rate was 2 percent and the average number of citations per region has ranged from 2.6 to 7.4. The measure is problematic from the following standpoints:

- Included in these scores are not only deficiencies related to quality of care and quality of life, but also deficiencies for physical plant issues often most noted in older buildings.
- Surveys other than the most recent survey should be excluded from consideration. The measure would reflect survey deficiencies from several years ago, even though the facility's more recent performance may be excellent.

Quality Measures

This portion, which comprises 60 percent of the overall composite score for each facility, is based on five CMS QMs measuring the percentage of residents: (1) who have had a catheter inserted and left in their bladder; (2) with a urinary tract infection; (3) who lose too much weight; (4) whose need for help with activities of daily living has increased; and (5) whose ability to move about in and around their room decreased.

In general, using these measures is highly problematic due to the lack of "risk adjustment." While CMS states all the measures are risk adjusted, in fact the risk adjustments are very limited and do not begin to address the most important patient issues related to these outcomes. The facts about each QM/Quality Indicator used in the rating are discussed in detail below.

Because this is true, facility rates are largely determined by the types of residents they admit whereas if they were properly adjusted for resident population characteristics (this has been done in acute care/hospital/surgery for years), one facility could be validly compared to another based on quality of care provided. Importantly, this is a disservice to the residents because many critical quality of care problems are missed or buried. One of the leading academics and key developer of the MDS/QMs, Dr. Vince Mor, stated in 2006:

> "The impetus to apply the emerging set of quality 'tools'…may have outstripped the evidence for their valid application in selecting top providers or for rewarding their superior performance. Observed differences in quality measures could be a result of different providers serving different types of patients—making it difficult to determine whether differences are due to real differences in quality. Additionally, observed differences in provider quality measures may be due to how providers go about assessing their patients. Researchers and government have a responsibility to make sure that the technical aspects of the QMs being used to compare NHs are up to the challenge of being used both to stimulate the org changes needed to redesign care processes to improve care and to allow for legitimate and valid comparisons across providers."[1]

[1] Mor, V, *Defining and Measuring Quality Outcomes in Long-Term Care*, JAMDA, October 2006, pp. 532-540.

Indeed, the original QMs were never validated or designed to identify facilities providing superior care—there were intended as indicators of potentially poor care for further investigation, nothing more.

As previously noted, a workgroup that included experts from DOH, NYAHSA, NYSHFA and HANYS spent several months reviewing QMs appropriate for use in a $3 million pay-for-performance demonstration enacted in the SFY 2006-07 budget. These experts concluded that none of the existing CMS QMs were useful or accurate enough to be used for rewarding facilities for good care, due to the lack of appropriate risk adjustment. It was decided to use a risk adjusted pressure ulcer measure NYAHSA developed through a patient safety grant, and to build on that in future years with other validated risk adjusted measures. It seems incongruous that DOH would now use five of the rejected measures in this initiative.

The catheter and urinary tract infection (UTI) measures may be suitable for use, although there are certainly conditions that affect the likelihood of a UTI or the need to use a catheter. There is a risk adjustment for catheters that looks at the percentage of residents with either bowel incontinence or a stage 3 or 4 pressure ulcer (i.e., bed sore). Since we expect facilities with a lot of residents with these conditions to have a higher rate of catheter use, their rate is risk adjusted down. This could inappropriately "reward" a facility with a high number of advanced stage pressure ulcers. We recommend risk adjusting QMs only for conditions that are out of the control of the facility. We also have questions about the accuracy of UTI coding on the minimum data set (MDS) patient assessment, the source document for this data.

The other three measures—weight loss, activities of daily living (ADL) change and mobility change—are very problematic and highly influenced by a facility's resident population:

- Weight loss is not risk adjusted for factors that can lead to unpreventable weight loss, including end stage disease (it excludes those in hospice, but not others who are in the process of dying), cancer and HIV/AIDS.
- ADL change is not risk adjusted. There are a few exclusions which could be considered partial risk adjustment, but they do very little in practice:

  (1) The measure excludes residents who cannot decline further in function. The result of this exclusion is that facilities that may provide very poor care and have far more residents who have declined to the point of needing total assistance in the four activities of daily living (bed mobility, eating, transfer and toileting) are not considered in their rate, so these facilities would in fact be "rewarded" for having most of their residents totally functionally dependent. They also get more reimbursement this way since these residents have higher case-mix scores than more functionally independent residents. What incentive would these facilities have to try to improve residents' functionality, which may be possible with the right nursing restorative programs and other interventions?
  (2) The measure also excludes residents who are comatose, have end-stage disease (6 months or fewer to live) or are in hospice. In practice, this excludes a very small number of people (only about 5 percent in total), which has very little effect on any facility's rate on this QM.
  (3) Importantly, this measure does not risk adjust for diseases and conditions outside of the control of facilities, but put residents at far greater risk for functional decline. For example, NYAHSA's research shows that residents with dementia decline much faster than cognitively intact residents; thus facilities with large dementia/Alzheimer's

populations tend to have higher rates of ADL decline. Older residents and males are also much more likely to decline, so facilities with older populations or primarily male populations are likely to fare worse on the QM. High body mass index (BMI)/obesity is a risk factor for functional decline, and facility residents in New York have had a large increase in BMIs over the past 10 years. Residents with diseases/conditions such as multiple sclerosis, Parkinson's, lung disease and antibiotic resistant infections are twice as likely to have ADL decline. Thus, there are far more risk factors that should be considered to validly compare facilities on preventing ADL declines.

- Mobility change is risk adjusted using a small number of risk factors:

  (1) The proportion of residents with a recent fall puts residents at higher risk for mobility decline (which is the resident's ability to move in and around their room measured by the locomotion ADL). This means the more residents with falls, the higher the facility mobility decline rate will be, and the more their rate is risk adjusted downward to account for this. Again, this can reward facilities with high rates of falls, which are often preventable and under the control of the facility.
  (2) Residents needing extensive or total assistance in eating or toileting are considered higher risk and have same impact on the facility risk adjusted rate. It is not clear why needed assistance in eating or toileting should lead us to expect that residents are more likely to not be able to move around their room, given the appropriate care and assistance. This risk adjustment is puzzling.
  (3) This measure uses the same exclusions as the ADL decline measure above, with the same limitations noted above.
  (4) This QM does not include resident risk factors that might impact the ability move around the room such as balance/gait problems and osteoporosis/bone density related fractures.