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New Rate Setting System for Nursing Facilities

A Report to the Minnesota Legislature

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Recommendations to the Minnesota Legislature

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I. INTRODUCTION

Laws of Minnesota, 2005, First Special Session, Chapter 4, Article 7, Section 43, directs the Department of Human Services (DHS) to bring recommendations to the Legislature, by Feb. 15, 2006, regarding determining operating payment rates for nursing facilities. The requirement states:

> *The commissioner shall provide recommendations to the legislature by Feb. 15, 2006, on specific methodology for the establishment of the operating payment rate for direct care and support services under the new system. The recommendations must not increase expenditures for the new payment system beyond the limits of the appropriation. The commissioner shall include recommendations on options for recognizing changes in staffing and services that may require a supplemental appropriation in the future.*

In addition, Laws of Minnesota, 2005, First Special Session, Chapter 4, Article 7, Section 60, directs DHS to bring recommendations to the legislature, by Feb. 15, 2007, regarding determining property payment rates for nursing facilities. The requirement states:

> *The commissioner of human services shall provide recommendations to the legislature by Feb. 15, 2007, on changes to the current nursing facility property payment system.*

This report is submitted to the Legislature in response to these requirements.

Minnesota Statutes, Chapter 3.197 requires reports to the legislature to identify the cost of preparing a report. The cost for preparing this report was XX.

II. BACKGROUND

In recent years, DHS staff and many stakeholders, including nursing facility representatives, consumer advocates, and labor representatives, have invested time and effort to reform the nursing facility payment system from the current mix of the cost-based Rule 50 system, which was first implemented in 1985, and the rate-on-rate Alternative Payment System, which was first implemented in 1996. The following is a brief summary of changes implemented or considered for setting payment rates.

1. Alternative Payment Demonstration Project: 1995-present

In 1995, authority for the contractual Alternative Payment System (APS) was enacted. This voluntary system is an alternative to the prospective cost-based system known as Rule 50. Rule 50 required detailed cost reporting and derived payment rates based on reported, allowable costs. In contrast, APS eliminated cost reporting and set rates based on an inflation adjustment applied annually to existing rates. APS issues contracts through Requests for Proposals (RFPs).

The law limited APS participation to up to 40 facilities in each of the first three RFP rounds and also required the department to issue new RFPs twice each year. By the end of 2005 over 300 facilities were operating under APS contracts. Legislation enacted in 2005 creates an incentive for the 100 remaining facilities still under Rule 50 to enter APS by Oct. 1, 2006. It is anticipated that almost all nursing facilities will elect to enter the APS system.

A feature of the APS contracts was the authority of the department to negotiate performance incentive payments of up to 5 percent, based on achievement of negotiated performance measures. This feature was never implemented because DHS and stakeholder representatives were unable to agree on what measures were to be used, and because no funds were appropriated for this purpose.

A concept basic to APS is that facilities receive a great deal of flexibility in regard to financial operations. Costs are not reported, rate adjustments are based on inflation and efficiency is rewarded because reduced costs do not lead to lower rates. It was envisioned that facilities would be more free to manage their businesses, with no interference from the state in regard to their spending, and that this would lead to greater efficiency and improved quality. In fact, during most years the state has provided rate adjustments that were larger than prescribed by APS law and much of the newly provided funds were prescribed for specific uses.

The drawback to APS is that it does not recognize differences in nursing facilities' costs or correct for historic inequities in payment rates. It was envisioned that APS would last for four or five years and then a new system would be adopted.

2. Performance-Based Contracting: 1998-2000

The department and an advisory committee worked from 1998-2000 to develop a new, Performance-Based Contracting system (PBC). While similar to APS, PBC placed more emphasis on rewarding outcomes. PBC was not implemented because of a lack of agreement on what outcomes and quality measures would be recognized. Nursing facility representatives also wanted a system that permitted negotiation of the price for services provided. Such a system could have corrected some of the historic disparities in rates paid to facilities. These and other implementation issues became barriers to adoption of this proposal.

3. Value-Based Reimbursement: 2001-2005

Over the next four years, efforts continued to develop a new payment system. In 2001, the Legislature directed DHS to develop recommendations for a new payment system. DHS enlisted the support of a University of Minnesota consulting team led by Dr. Robert Kane. The U of M team provided advice and analysis to assist in the design of a new payment system proposal, as well as three other major projects:

- The development of a quality profile for nursing facilities
- An analysis of the need for a staffing standard for direct care staff in nursing facilities
- A Staff Time Measurement study to evaluate the indices or weights associated with the Resource Utilization Groups (RUGS) case mix groups implemented on Oct.1, 2002.

Advisory committees were formed to assist with each of these projects, with members representing providers and their trade associations, consumers and organized labor.

The new payment system design work resulted in a report, delivered in March 2004 and entitled "Value-Based Reimbursement: A Proposal for a New Nursing Facility Reimbursement System." The report can be seen at:

http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_020477.pdf

The Value-Based Reimbursement (VBR) proposal entailed establishing operating payment rates based on costs, a target price and quality.

The proposal included:

- A method for measuring quality in nursing facilities. Quality is measured by staff/resident ratio, staff turnover, staff retention, use of nursing pools, assessment-based indicators of clinical quality, percentage of single rooms in the facility, and inspection results from the Minnesota Department of Health. After years of effort on the part of department staff and stakeholders, there was general agreement on these measures. This was a significant achievement.
- Definition of four payment rate components – direct care, support services, external fixed and property.
- Timeframes and methods for reporting costs and statistical data.

- Formulas for determining operating payment rates
- A method for setting property rates.

This proposal was not enacted because of concerns on the part of nursing facility industry representatives, who were concerned that:

- Nursing facilities may eventually receive reduced rates, even as moderated by the proposed phase-in
- The model made it difficult for facilities to predict future revenues
- All facilities have an opportunity to receive rate increases to help them adapt to a new system
- Not enough modeling had been done
- The new system may not provide rate increases sufficient to pay for investments in quality improvement.

Late in the 2004 legislative session, industry representatives and DHS staff agreed to collect baseline statistical and cost data from all facilities and bring new recommendations to the 2005 Legislature. This provided improved data and more time to design and model the new system.

Baseline data was collected during the summer of 2004 and intensive modeling and negotiating took place during the six to eight months following the 2004 session. In place of the larger advisory committee a smaller negotiating committee was established, this time with only two representatives from each stakeholder group. A modified version of VBR was then recommended to the Legislature in 2005. The LTC Imperative (a collaboration between the Minnesota Health and Housing Alliance and Care Providers of Minnesota, the two trade associations representing Minnesota's nursing homes) voiced many of the same concerns that had been expressed a year earlier.

4. Direct Care Staffing Model: 2005

Negotiations between DHS and stakeholders continued throughout the 2005 session and led to a new proposal developed by the LTC Imperative. The new proposal addressed only operating costs, and did so in a new way. Under this proposal -- the Direct Care Staffing (DCS) model -- the primary emphasis was placed on staffing levels. Like the VBR proposal, operating payment rates consisted of two components, direct care and support services, and recognized three peer groups of facilities: hospital attached/Rule 80/ frequent admission; Boarding Care Homes; and other. For direct care (costs related to nursing, activities and social services), the rate would be a function of staffing level with higher rates being associated with higher levels of staffing. Changes in staffing from one year to the next could result in rate changes.

The payment rate for support services (costs related to dietary, housekeeping, laundry, maintenance and administration) would be a set price for all facilities. In addition, the proposal provides an add-on to the operating payment rate based on the facility's quality score. The quality add-on would be funded with new money.

To control cost increases, in the event that facilities increased staffing levels rapidly, the LTC Imperative agreed to limit the amount of staffing increases that could be recognized to 5 percent per year. When DHS and the LTC Imperative shared this proposal with legislative leaders, the 5 percent limit was not acceptable and the proposal was further amended to preclude recognition of any change in staffing without a prior authorization and appropriation from the Legislature. This made the proposal less attractive for stakeholders, who advocated for additional funding to be available to support increases in staffing levels.

Being at an impasse, DHS advocated for any new funding appropriated in the 2005 session to be directed to nursing facilities to be used for a quality add-on, using the structure proposed in the DCS model. The LTC Imperative suggested, if a quality add-on is adopted, to begin it in the next biennium so facilities would have an opportunity to work toward improvements in their quality scores. A compromise resulted in enactment of language calling for 40 percent of the Oct. 1, 2006 rate increase to be used for a quality add-on.

A basic framework for a new payment system was enacted as well, but critical specifics for setting operating and property rates were replaced with requirements for further recommendations. The negotiating committee resumed its work to consider models of payment.

It should be noted that there are several issues the VBR and DCS models have in common:

- Peer groups – both models recognize that the industry consists of three peer groups of facilities:
  - Facilities that are hospital attached, have frequent admissions or are licensed under Rule 80
  - Boarding Care Homes
  - All others.
- Geography – the issue of how to recognize legitimate geographic variation in a payment system remains unresolved. The negotiating committee has considered using MSAs, economic development regions and making no distinctions. A drawback of systems that have been used previously is that fixed lines always seem to create problems. Two facilities in close proximity but on opposite sides of some line and treated differently will always result in one of them feeling they are not being treated fairly. Wherever the lines are drawn in any system, some sort of a grey zone in which a blending occurs would be useful.
- Specialized care facilities – both models recognize that specialized care facilities present issues that need to be resolved in order to preserve access to the needed services they provide. Uncertainty remains as to how to define this group of unique facilities, how many there are and how their needs should be addressed.
- Phase in – both models provide for a four year phase-in with some sort of a hold harmless for facilities that would otherwise experience large rate reductions.

III. CONTINUED NEGOTIATIONS AND IDEAS CONSIDERED

In an effort to develop a recommendation for the operating payment rate components of a new nursing facility payment system, DHS reconvened the negotiating committee, with the first meeting on Sept. 1, 2005. The group had before them two models, plus a number of options to modify or merge portions of these models. Between September and January 2006 the committee met 13 times. The following are ideas considered:

1. Refine the Direct Care Staffing Model

The negotiating committee first attempted to resolve concerns with the DCS model. There were several concerns with the model, including:

- The weak correlation between staffing levels and quality of care
- The concern that the incentives inherent in the model could constrain wages and benefits
- The potential for increases in overall MA nursing facility costs resulting from the model
- The overall risk inherent in a system that redistributes funding. To compensate for this risk, stakeholders wished to implement a new payment system with new funding for staffing increases, inflation adjustments, hold harmless provisions and funding to ease transition to the new system.

After considerable discussion, agreement was not reached on how to address these concerns.

2. Refine the Value-based Reimbursement Model

The negotiating committee then reviewed the VBR model, but little interest was evident in returning to that model. Some discussion also took place regarding how the two approaches might be combined. No compelling solutions arose.

3. Conduct a demonstration

In October, DHS suggested implementation of a voluntary demonstration project to test a new payment approach. It was evident that the reforms proposed were dramatic and there could be unanticipated consequences. Demonstration of a payment model could reduce the risks stemming from those unanticipated consequences. The department believed a sufficient number of facilities would be interested in participating in a demonstration for one to be conducted.

The goals of a demonstration would be to:

- Determine if the incentives improve quality
- Determine if the incentives improve efficiency
- Understand the impact of the model on the financial performance of facilities
- Identify implementation issues and devise solutions before applying the model to the entire industry

- Better understand the cost trajectory of the model to be able to more accurately estimate the cost of adopting the model to the entire industry.

After some consideration, the demonstration idea was rejected. Industry representatives were concerned that a demonstration would provide funding to only a limited group of facilities. They did not want to see benefits made available only to some facilities and not be available to all facilities. Concern was also expressed that a demonstration project would delay state-wide implementation of reform in the payment system.

4. Consider incremental changes to improve the payment system

DHS suggested to the negotiating committee that an impasse existed with regard to developing consensus on a major reform proposal and suggested exploring any incremental steps that could be agreed to that would lead to improvements in quality. Several ideas were explored, but no recommendations were developed.

IV. ACCOMPLISHMENTS

There has been substantial work on the part of many stakeholders and department staff to develop a new payment system. However, consensus appears to be unreachable at this time. This means that APS will continue, at least for the next few years.

Although agreement was not reached on a new payment system, many ideas were explored, researched and modeled. The concepts developed through these efforts are available to policy makers, advisory committee members and department staff and may serve as a basis for future efforts.

In addition, these efforts have produced some important accomplishments:

- In 2002, a new case mix system based on Resource Utilization Groups (RUGS), was implemented. This system streamlined assessment processes for nursing facility staff by eliminating duplicative assessments and documentation.
- In 2003 and 2004, a Staff Time Measurement study was conducted to evaluate the indices associated with the RUGS case mix groups. There are several options available for adjusting the indices, either on a budget neutral manner or through an additional appropriation.
- In 2005, at the Legislature's request, an analysis was completed regarding the need for a staffing standard for direct care staff in nursing facilities, providing objective research on the relationship between staffing levels and quality of care. It showed that the association between staffing level and quality of care was weak, suggesting that a higher required level of staffing may not be the most effective and efficient policy for improving quality.
- In 2005, for the first time, the Legislature specified that a portion of the funding increase granted to nursing facilities, effective Oct. 1, 2006, be targeted to those facilities that demonstrate quality performance. In addition to a cost-of-living increase, facilities have the opportunity to earn up to an additional 2.4 percent increase by demonstrating quality in five measured categories.
- In 2006, Minnesota made public a comprehensive "report card" of all certified nursing facilities in the state. Citizens can now get easy-to-understand information about the quality and services provided by nursing facilities and consumer satisfaction information from surveys of the residents who live at the facility. This helps people to make more informed decisions about nursing facility care for themselves or for their family members. These quality profiles reflect years of effort on the part of state agency staff, industry representatives, consumer advocates, worker representatives, and many other stakeholders.
- Effective Oct. 1, 2006, the last barriers that resulted in some nursing facilities staying in the old Rule 50 payment model will have been eliminated and virtually all MA nursing facilities are expected to choose to move into APS.

V. RECOMMENDATIONS

DHS recommends building on the successes that have been accomplished by continuing efforts to adopt **incremental improvements** in the payment system to:

- Encourage efficiency and quality
- Reduce disparities
- Give providers financial incentives for delivering quality services
- Achieve good outcomes for residents.

As previously stated, the negotiating committee was not successful in agreeing on recommendations and it is likely certain stakeholder groups will bring forward their own recommendations. Therefore, the following are the Department of Human Services recommendations:

1. Consider adopting performance incentive payments.

DHS recommends implementing the performance incentive payments that were part of the original legislation in the APS Law. This would provide an additional tool for encouraging quality. In addition to the quality score that will lead to a quality add-on, facilities could propose to earn a performance incentive payment by achieving outcomes that would improve quality, contribute to increasing the efficiency of the overall long term care system or achieve other policy goals that facilities and the state are interested in achieving. The costs of this proposal could be funded by redirecting the funding appropriated in 2005 for the hold harmless in the new payment system.

2. Consider adopting case mix quarterly reviews.

The biggest single issue resulting in complaints from consumers in regard to the RUGS case mix system adopted in 2002 is that they pay a higher rate for six full months because the nursing facility resident, while in the hospital prior to nursing facility placement, had either IV therapy or oxygen therapy. While the costs of their care may be higher for the first several weeks, these costs tend to decline as the residents condition improves. This issue would be largely resolved by using all quarterly assessments rather than the six month assessment to set RUGS classifications. A budget neutral method can be used to rebase each facility's rates so facilities will not experience a revenue reduction resulting from this change.

3. Consider adopting new case mix indices.

The negotiating committee had agreed to implement the newly developed RUGS indices as part of the new payment system. This no longer seems likely, so a decision is needed regarding the use of the new indices. The implementation can be done in a variety of ways. Current law gives DHS authority to implement them using the formula provided in statute. While this formula does not achieve a perfectly budget neutral transition for every facility, it is far better than not using the formula, which would result in a great deal of redistribution of funding. A third alternative would be to implement the new

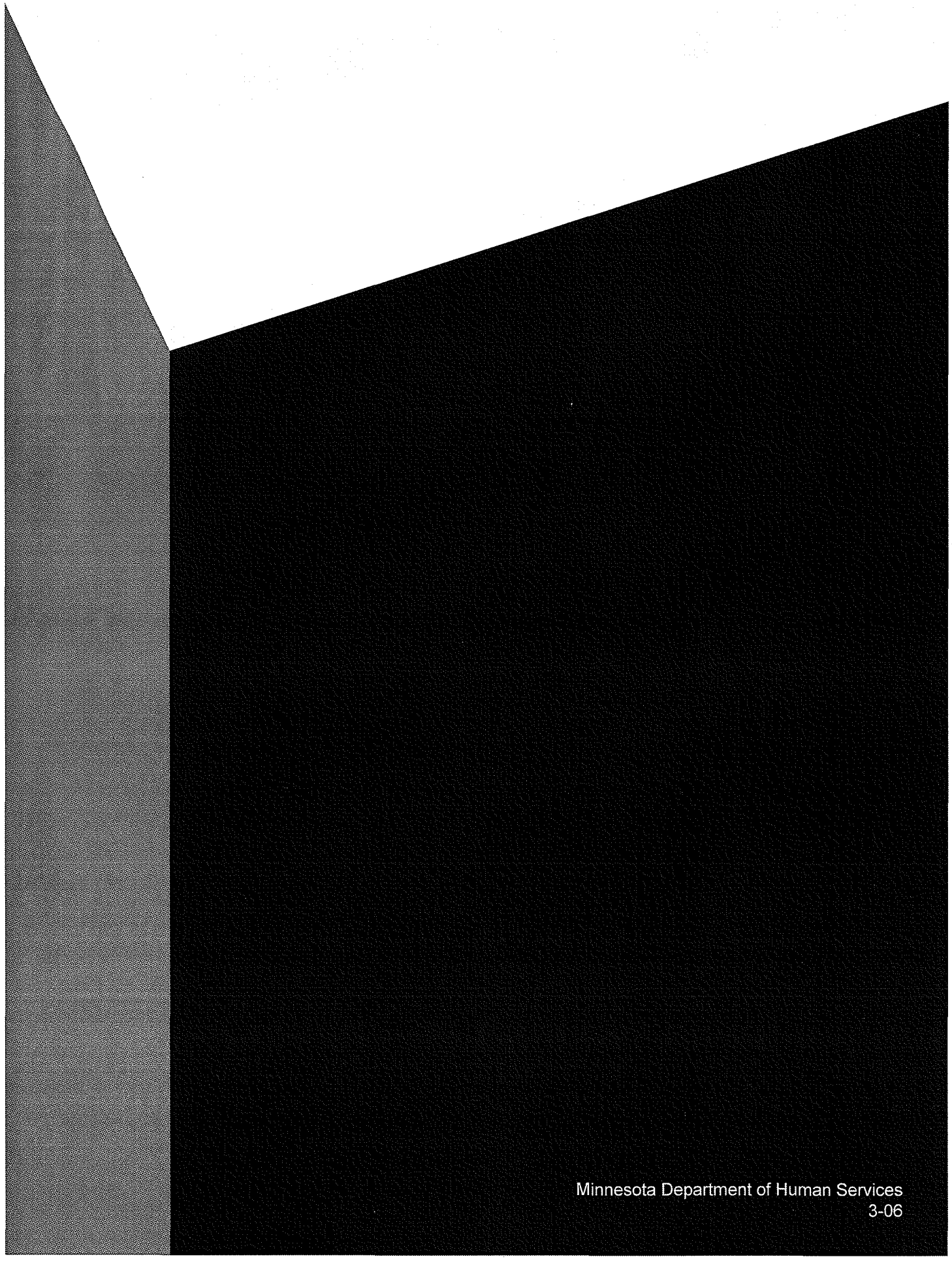
indices without the budget neutral formula and hold all facilities harmless against any loss of revenues.

DHS recommends that the issue of implementing the new indices be examined during the 2007 legislative session when complex budget proposals can be more thoroughly examined.

4. Continue Work on the new payment system.

DHS is committed to working with policymakers, advisory committee members and other stakeholders to continue to seek agreement on a new reimbursement system, including continued efforts to examine the models developed so far, consideration of new models or incremental changes to the existing system.

At present, no further meetings of the advisory committee are scheduled. A break in these efforts may be beneficial to all parties in order to examine what has been accomplished and define how to move forward from here. DHS will resume negotiations as ideas emerge for consideration.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