Overview of Nursing Homes

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Capacity & Utilization

<u>Beds (November 2016 data):</u>

- 39 Nursing Homes
- 36 homes accept Medicaid
- 3 homes closed since 2012
- 3002 total beds
- 2925 Medicaid beds
- 305 fewer beds in 2016 than in 2010
- Average statewide occupancy **<u>84%</u>**

<u>Utilization:</u>

63% Medicaid (long term care)
16% Medicare (short stay, post acute care)
13% Private Pay (long term care)

Financial Considerations

Provider Tax:

- Assessed maximum allowable under federal law @ 6% revenues
- Assessed on a per bed basis @ $4,919.53
- Medicaid, Medicare and private pay beds
- Total SFY'16 provider tax paid $15.3 million
- Leverages FMAP for Vermont Medicaid program

Medicaid Shortfall:

- Difference between actual cost of care and Medicaid reimbursement
- Estimated $10.8 million in 2013 (most recent data)
- Estimated difference in Medicaid rate v. Medicaid cost in 2015 $17.76/day

https://www.ahcancal.org/research_data/funding/Documents/2015%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf

Medicaid Rate Setting

- $221.60/day last quarter average Medicaid rate (does not include VVH)------ $9.23/hour

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- Rates are cost based, set quarterly for "allowable costs"
  - Nursing care (i.e. RN, LPN, LNA)- acuity adjusted as incentive to take higher acuity
  - Director of Nursing
  - Resident care (i.e. food, activities)
  - Indirect care (i.e. administrative, plant operation & maintenance, housekeeping/laundry)
  - Property (i.e. depreciation, interest, insurance)
  - Ancillary (i.e. medical supplies, incontinence supplies, therapies)

- Examples of penalties
  - Occupancy below 90% (current statewide occupancy 84%)
  - Median limits for resident care & indirect
  - Nursing at 90th percentile

- Uses a base year- current 2013 costs for all costs but nursing (2011- will begin using 2015 costs 7/1/17)
- Annual inflation adjustment to "catch up" for outdated base year costs- roughly 2%
- http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/adopted-rule-effective-6march2015.pdf

Rate Setting

33 V.S.A. § 901. Reimbursement objectives

Reimbursement rates for nursing homes shall reflect the following objectives:

(1) maintain an equitable and fair balance between cost containment and quality care in nursing homes;

(2) encourage nursing homes to admit persons without regard to their source of payment;

(3) provide an incentive to nursing homes to admit and provide care to persons in need of comparatively greater care;

(4) be manageable administratively for both the State and nursing homes; and

(5) prevent unnecessary cost increases.

Rate Setting

33 V.S.A. § 904. Rate setting

(a) The Director shall establish by rule procedures for determining payment rates for care of State-assisted persons to nursing homes and to such other providers as the Secretary shall direct. The Secretary shall have the authority to establish rates that the Secretary deems ***sufficient to ensure that the quality standards prescribed by section 7117 of this title are maintained***, subject to the provisions of section 906 of this title. Beginning in State fiscal year 2003, the ***Medicaid budget for care of State-assisted persons in nursing homes shall employ an annual inflation factor which is reasonable and which adequately reflects economic conditions***, in accordance with the provisions of Section 5.8 of the regulations promulgated by the Division of Rate Setting ("Methods, Standards, and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities").

http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/1adopted-rule-effective-9sept2013.pdf

42 U.S.C. §1396a(a)(30)- Medicaid State Plan must provide "… payment for care and services … as may be necessary to safeguard against unnecessary utilization of such care and services and to ***assure that payments are consistent with efficiency, economy, and quality of care***…."

Regulatory: Federal

- Medicare & Medicaid only pay facilities if in compliance with federal CMS regulations, 42 CFR Part 483, Subpart B, *Requirements for Long Term Care Facilities*

  - *Resident rights*
  - *Admission, transfer, discharge requirements*
  - *Resident behavior and facility practices*
  - *Quality of life*
  - *Quality of care*
  - *Resident assessment*
  - *Nursing services*
  - *Physician services*
  - *Dietary services*
  - *Dental services*
  - *Specialized rehabilitiative services*
  - *Pharmacy*
  - *Infection control*
  - *Physical environment*
  - *Administration*

Regulatory: State

DAIL Nursing Home Licensing and Operating Rules: governs requirements to obtain a license to operate and generally adopts federal standards (as above) as the state level requirements:

http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/nursing-home-regulations

VT Nursing Rules: promulgated by Board of Nursing and governs training, competence, standards of practice, and unprofessional conduct.

https://www.sec.state.vt.us/media/656823/Adopted-Clean-Rules-Dec-23-2014.pdf

VT Nursing Home Administrator Rules: promulgated by Office of Professional Regulation and governs competence, training and unprofessional conduct.

https://www.sec.state.vt.us/media/166616/NHA_Rules.pdf

Regulatory

- DAIL Division of Licensing & Protection conducts unannounced compliance surveys on an annual basis to determine compliance with federal and state regulations
- Federal surveyors often attend with state staff
- CMS may conduct its own survey
- Surveys are conducted in accordance with the CMS *State Operations Manual-* 733 pages that instructs surveyors as to the following:
  - *How to survey*
  - *How to rate scope and severity of survey findings/citations*
  - *How to require and use plans of correction to remedy survey findings/citations*
  - *How to impose remedies/financial penalties*
  - *Process for nursing facilities to challenge citations*

Regulatory- Ownership

Federal Rules- 42 CFR Part 483, Subpart B- CMS requires disclosure of ownership, or financial or controlling interest, to Medicaid and Medicare:

- Upon submission of provider application
- Upon execution of provider agreement
- Upon change of ownership
- At time of survey (compliance)

Failure to comply with federal rule- don't get paid

State licensure requirements also govern disclosure of ownership, Rule 17.2:

- Upon application for licensure, which is required to operate- a license is required to receive a provider and billing number for Medicaid and Medicaid
- Ongoing obligations to disclose at time of any change, if a change occurs in:
  - Person with an ownership or controlling interest of 5% or more, or convicted of Medicaid Fraud
  - Officers, directors, agents, managing employees
  - Corporation, association, or other company responsible for management
  - Administrator or director of nursing

Regulatory: CON

GMCB Rule

4.203 Change in Ownership for Health Care Facilities Other Than Hospitals

1. If a health care facility other than a hospital undergoes a change in ownership, corporate structure or other organizational modification such that a new license from the appropriate state or federal licensing entity is required, such action shall be a new health care project.

2. The transfer or conveyance of an ownership interest in a health care facility other than a hospital that fundamentally changes the financial stability or legal liability of the facility shall be a new health care project.

18 V.S.A. § 9434(a): a new health care project includes

(3) The offering of any home health service, **or the transfer or conveyance of more than a 50 percent ownership interest in a health care facility other than a hospital**.

Regulatory: CON Challenges

Predictability

Clear Process/Protocols

Timeframes

5 Star Quality Rating System

CMS web-based tool, *Nursing Home Compare*, to assist public in comparing facilities

Rating is based on survey data, staffing, and quality metrics (*long stay*: falls, UTI, pain, pressure ulcer, incontinence, catheters, restraints) (*short stay*: pain, pressure ulcers, vaccines, antipsychotic use)

Some structural challenges with the system:

- Grade on a forced curve- meaning 20% of facilities in every state will always receive 1 star on the survey component which accounts for more than 75% of final overall rating

July 2016 changes – added new quality metrics (*long stay*: ability to move, weight, depression, anti-anxiety/hypnotic meds, antipsychotic meds, flue/pneumo vaccine) (*short stay*: movement, re-hospitalization, ER visits, discharges to community)

Challenges

WORKFORCE

- Primary care
- RNs
- Direct care workers

Lack of mental health practitioners and resources

MMR