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RECOMMENDATION ON IMPLEMENTATION OF NEW RUGS INDICES

A Report to the Minnesota Legislature

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New RUGS Indices for Nursing Facilities

Recommendations to the Minnesota Legislature

Jan. 9, 2007

Prepared by the Minnesota Department of Human Services
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I. Introduction

Laws of Minnesota, 2006, Chapter 282, Article 20, Section 36, directs the Minnesota Department of Human Services to bring recommendations to the legislature, by December 15, 2006, on the weighting and implementation of case mix indices. The requirement states:

> *The commissioner of human services shall report to the legislature by December 15, 2006, recommendations on the weighting and implementation of case mix indices.*

This report is submitted to the Legislature in response to this requirement.

Minnesota Statutes 2006, Chapter 3.197 requires reports to the legislature to identify the cost of preparing the report. The cost for preparing this report was $250.

II. Background

Minnesota has had a case mix component to its nursing facility payment system since about 1985. The case mix system was implemented in order to fairly adjust payment rates for individual residents to vary with their respective needs and with the expected cost of caring for them. The goal is to pay a facility more for the care of a resident who is more costly to care for, and thereby create an incentive to admit and care for residents who have higher levels of need. As a Minnesota specific system, case mix required the periodic completion of an assessment form that gathered data on the resident's diagnoses, needs for assistance with activities of daily living, special treatments and so on. About 105,000 of these assessments were completed annually by either facility staff or staff from the Minnesota Department of Health.

Beginning in about 1992 the federal government began to require nursing facilities that participated in the Medicare or Medicaid programs to use the Resident Assessment Instrument, part of which is the Minimum Data Set (MDS), a lengthy and detailed assessment form. A few years later, facilities were required to begin submitting completed MDS forms electronically to the federal government through a state operated data repository. The MDS form is used for planning care, determining case mix classifications for Medicare, and quality assurance activities.

In order to reduce unnecessary paperwork Minnesota adopted a new case mix system on October 1, 2002, that used assessment data from the MDS and therefore allowed the state to eliminate the use of the Minnesota specific case mix assessment form. The state implemented the Resource Utilization Groups (RUGS) system using case mix weights, also called indices, which had been determined by the federal government. The RUGS indices used in Minnesota were derived from Staff Time Measurement (STM) studies

conducted in 1995 and 1997, in several other states, and primarily examined data on nursing home residents covered by Medicare.

Stakeholders were understandably anxious to move to the new system and accomplish the goal of paperwork reduction, and agreed to implement the new system using the federal indices, but only to use them temporarily. In order to customize the indices for Minnesota's use, DHS conducted a legislatively mandated STM study during 2003 and 2004. New indices have been developed and the purpose of this report is to recommend to the legislature if the new indices should be implemented, and if so, the method for their implementation.

When the transition to RUGS took place in 2002, a formula was used to ensure that the transition did not alter the revenues of nursing facilities. Since the primary goal was to eliminate unnecessary paperwork, the department and stakeholders agreed to a budget neutral transition formula to be used in moving from the old case mix payment rates to the new RUGS rates. The formula, authorized in M.S. 256B.438, Subd. 7, adjusts facilities' base rates related to case mix related costs. The base rate is a dollar value that is multiplied by case mix indices to determine the case mix related portion of the operating payment rate. The transition formula requires the use of extensive historical data on resident days by case mix class. Using the old indices and the new indices, a new base rate is determined so that revenues under the new indices will be equal to the revenues that a facility would have received under the old indices. Subdivision 3 of M.S. 256B.438 permits DHS to annually rebase payment rates using this formula to transition to new indices which incorporate new data on average direct care staff wages or findings from new staff time measurement studies.

DHS considered implementing the new indices in 2005 when the analysis of the STM was completed, in combination with the phasing in of a new reimbursement system. This was an approach that the department and stakeholders had agreed upon. However, no agreement was ever achieved on how the new reimbursement system would work, and so the new indices could not be implemented in this way. DHS then considered implementing the new indices under the existing statutory formula, but learned that nursing home industry advocates were opposed to this. The department decided to not implement the new indices at that time, and in 2006 the Long-Term Care Imperative (a collaboration of Care Providers of Minnesota and the Minnesota Health and Housing Alliance, nursing home trade associations) advocated for a legislative proposal to implement the new indices using a different methodology. This proposed methodology consisted of several steps:

1. The budget neutral formula would be used to determine interim transitional rates.
2. Facilities estimated in step 1 to have an increase in revenues under the new indices, and that would therefore receive a reduction in their base rate in order to achieve budget neutrality, would be permitted to retain their existing rates.
3. Facilities estimated in step 1 to have a decrease in revenues under the new indices, would receive an interim increase in their base rate in order to achieve budget neutrality.

4. Several months after the transition to the new indices, the department would examine the success of the transition in ensuring that no facility lost revenue, and would make further rate adjustments by:
    - Retroactively increasing the base rate of any facility that did not receive an interim transitional rate increase and that experienced a loss of revenue,
    - Retroactively increasing the rates of any facility that did receive an interim transitional rate increase and that nonetheless, experienced a loss of revenue, and
    - Allowing facilities that did receive interim transitional rate increases and that then experienced an increase in revenues, to keep their rate increases in their entirety.

The department estimates that this method, if enacted in 2007, will have an annual cost to the state of about $11 million. This proposal was not enacted in 2006. Instead, the legislature required the department to provide this report.

III. Recommendation

The department recommends that the new indices be implemented on or after January 1, 2008, in accordance with the facility specific, budget neutral formula that is currently in statute. This recommendation requires no new legislation. The department intends to take this step unless directed otherwise in legislation.

IV. Rationale

The department puts forth this recommendation for several reasons:

1. The new indices more accurately reflect the relative resource use of Minnesota nursing home residents than the current indices.

2. The 2002 transition to RUGS was intended to reduce paperwork. The implementation of the new indices represents the completion of that goal, and should not be used as a rationalization for providing new revenues to some nursing homes.

3. If new funding to nursing facilities is to be provided, it should be done to accomplish a specific policy goal. Distribution of rate increases to nursing facilities in accordance with the 2006 Long-Term Care Imperative proposal would have no apparent relationship to the relative needs, quality, potential to bring about benefits to residents or other features of the nursing facilities that would receive these increases. Some facilities would receive increased revenues, others

would not. The distinction would have no relationship to any particular policy goal.

4. The department believes that the transition formula written into current law is effective at achieving budget neutrality. This formula has been used twice. It was first used in the 2002 transition from the Minnesota Case Mix system to RUGS. In that transition there were a few facilities that expressed concerns that budget neutrality had not been achieved. Those concerns appeared to result from major programmatic changes that the facilities had implemented during the time between the data year and the transition, or they related to the fact that the change from the Minnesota Case Mix system to RUGS was such a major change. The formula was used again in October 2006 when the state began using all quarterly assessments to determine RUGS categories. While the 2006 transition appears to have gone smoothly, it is still too early to be certain that there were no budget neutrality problems resulting from that change. At the time of this writing, no problems have been brought to the attention of the department. The change to the new indices would be the simplest of the 3 changes, and should result in the fewest problems.

V. Stakeholder Comments and Department Response

Recognizing the potential for controversy surrounding the subject of this report, the department shared the report in draft form with stakeholders and requested their comments. Letters received in response to this request, from the Long-Term Care Imperative and the Seniors and Workers for Quality (a coalition of consumer advocates and labor unions), are in Appendix A.

The draft report has been edited to produce this final report. However, the department has chosen not to alter the recommendation or the rationale, and instead, to provide responses here to the comments from the stakeholders.

Long-Term Care Imperative

The Long-Term Care Imperative (LTCI) supports the department's recommendation to implement the new indices, but does not agree with the recommended method of implementation. The LTCI letter notes in paragraph 3 that, in RUGS, "behavior classes were 'under weighted' compared to more clinically complex conditions." We agree with this observation. The newly developed indices are more compressed than the indices in current use. In almost every case, RUGS groups with indices less than 1.00 moved up in value, while those with indices greater than 1.00 came down. The result of this change will be that, after implementation of the new indices, the difference in payment rates

between high needs RUGS groups and low needs RUGS groups will be reduced. See Appendix B for a comparison of the current and newly developed indices.

In paragraph 4 of its letter, the LTCI states, in reference to the use of the budget neutral formula, "This basically eliminates the impact of the new weights." The department disagrees. The case mix system has two goals:

- Eliminate the incentive to admit low needs residents rather than high needs residents by paying differently based on needs or resource use, and
- Provide more money to a nursing facility when it provides care to people who have greater needs than when it provides care to people who have lesser needs.

Both the current and new indices accomplish these goals. The new indices do so with a more accurate relationship between need level and payment level.

The formula in current law, which provides a method for transitioning to new RUGS indices, is designed to ensure that the transition does not result in greater or lesser revenues to nursing facilities. It does this by changing a facility's base rate to offset a change in its average RUGS weight. If the average index goes up as a result of the transition, then the base rate will go down, and vice versa. The current statutory method and the method that is recommended by the LTCI for transitioning to the new indices would both increase base rates for a facility whose average RUGS weight goes down because of the transition. But the method that is recommended by the LTCI would not lower the base rate in the reverse circumstance. This proposal might be seen as reasonable if there was some evidence that the direction of change of the average RUGS index were strongly associated with the adequacy or inadequacy of funding for a facility. The department is not aware of evidence of such a problem. The department believes a distinction needs to be made between: 1. differences in revenues between facilities with different case mix levels, and 2. differences in revenues that a particular nursing facility would receive if it had one particular case mix level as opposed to another. In the first case, the differences may result from a myriad of factors, such as historic cost levels, geographic disparities and to a small degree, differences in quality. In the second case the differences are desirable and will be reflected more accurately using the new indices than using the old indices.

The LTCI letter raises several issues regarding the adequacy of MA rates, rates paid to state operated facilities and unfunded mandates. While these may be worthy issues to discuss, the department views them as being outside the topic of this recommendation.

Seniors and Workers for Quality

The Seniors and Workers for Quality letter also supports the department's recommendation to implement the new RUGS indices, and also disagrees with the department's recommended method of implementing them. They recommend the implementation be done with increased funding for the behavior classes. The department believes that an increase in indices for these RUGS groups and increased funding for them would result in an incorrect bias in the case mix system. The indices are the

mechanism for balancing resident needs with funding. The adequacy of funding for any particular type of care level, should be the same as the adequacy of funding for any other type of care level. The purpose of the Staff Time Measurement study that was conducted was to establish indices on an empirical basis. Again, without engaging in a discussion of the overall adequacy of funding, we note that the department believes that more accurate RUGS indices are needed, and should not be confounded with other issues that may or may not have merit.

APPENDIX A

COMMENTS FROM STAKEHOLDERS

The Long-Term Care IMPERATIVE

A Minnesota Collaboration for Changes in Older Adult Services

Date:	November 10, 2006
To:	Bob Held
	Valerie Cooke
	Loren Colman
	Minnesota Department of Human Services
From:	The Long Term Care Imperative
RE:	Response to draft report on RUGS indices

We appreciative the opportunity to comment on the draft report and to share the serious concerns we have with the Department of Human Services (DHS) recommendations. You will note that we have expressed many of the following concerns to you in the past, but there are also some new issues that have surfaced since our last discussion.

In short, we do agree that the state should adopt the new case mix weights. However, we do not support implementing the case mix weights on a budget neutral basis.

I. Need to Adopt New Weights

In 2002, Minnesota converted to a case mix system that utilizes 34 Resource Utilization Groups or RUGS, which is the federal case mix system used under Medicare. One of the major concerns with using the RUGS system we had at that time was that the behavior classifications were not weighted heavily enough. In 2001, the Minnesota Legislature funded a staff time study designed to lead to new RUGS weights for Minnesota that would more accurately reflect the costs of providing care to residents in certain classifications. The staff time study released in July, 2004 showed that in general, the behavior classes were "under weighted" compared to more clinically complex conditions. The result of the time study was a new and more accurate set of RUGS weights for nursing facilities that should be adopted.

II. Need to Recognize Costs Associated with New Weights

Current law allows DHS to implement the new weights on a facility specific, budget neutral basis. Under that approach, facilities that would receive an increase based on residents in classifications with the new higher weights would then have their base rates reduced to maintain budget neutrality upon the transition. This basically eliminates the impact of the new weights. Moreover, since the current Medicaid rates do not cover Medicaid's actual share of costs, the budget neutral approach simply maintains this funding shortfall. Absent a full cost rebasing of nursing facility rates with the new case mix weights, implementing the more accurate case mix weights without the facility-specific budget language would be a step in the right direction, and would also recognize the additional staff resources spent addressing behavior issues.

Interestingly, your own agency has continually recognized the increased costs associated with providing care for individuals with behavior issues at Ah-Gwah-Ching. According to the State Register, on July 1, 2006 the charges for care at Ah-Gwah-Ching were increased to $801 per patient day. Although this facility is will be closed in the near future, Ah-Gwah-Ching's daily rates have historically been hundreds of dollars per day greater than the non-state owned nursing facilities that care for very similar populations.

III. New Federal Mandates

Since the passage of the enabling legislation in 2002, and the development of the new weights in 2004, there have been several changes to the interpretive guidelines for nursing facility regulation that are especially costly to implement for nursing facilities serving residents with behavioral problems. While there have been many new requirements this year, the two that require additional non-nursing specific time are the "New Psychosocial Outcome Severity Guide" and "Issuance of Revised Activities Guidance". The activities guidance, for example, is considerably different from previous guidance for tag F248. The emphasis on resident activity and its close linkage to person-centered care, quality of life, self-esteem, and psychosocial outcomes is apparent in this guidance.

IV. Other Issues

We would all agree that the case mix indices are a multiplier to base rates that have little correlation to actual costs of providing care, which is why we had originally proposed changing the indices when we changed the payment system. Changing the weights used as a multiplier to "meaningless" numbers isn't the ideal solution to the identified problem of resource allocation, but it is all we have right now, given that a new payment system has not been implemented. However, in the approach we are suggesting, we at least accomplish something by giving some facilities the additional resources they need to address issues like caring for individuals with behavior problems. The DHS approach, essentially, does nothing to address resource allocation issues.

Summary

We are asking DHS to reconsider our recommendation for how to implement the new case mix weights – a method that would allow facilities who benefit from the new weights to receive higher rates.

- We believe our approach better targets state resources in a way that serves residents who are known to require more time than the current system shows.
- If DHS is unable to support a recommendation that implements the new weights with the corresponding targeted rate increases, we would recommend that you NOT proceed with the budget-neutral implementation of the new weights. Rather, we think it would be better public policy to delay implementation of new case mix weights until such time that a new payment system is implemented, or until there is a significant rebasing of the rates.
- Facilities have been through the budget neutral process twice in the last few years, and there is absolutely no reason to do it again when the result is that facilities will be receiving essentially the same revenue after the change as before.

SENIORS and WORKERS for QUALITY

A Coalition of Caregivers and Organizations Who
Represent the People at the Heart of Long-Term Care
PO Box 1801 – St. Paul, MN 55101

November 10, 2006

Robert Held, Continuing Care Program Manager, and
Valerie Cooke, State Program Administration Director
Minnesota Department of Human Services
504 Cedar Street
St. Paul, MN 55155

Dear Bob and Valerie,

This letter is a reply to the request for comments on the Department of Human Services' (DHS) draft legislative report on the weighting and implementation of case mix indices for nursing home reimbursement. Seniors and Workers for Quality opposes the DHS recommendation and suggests an alternative approach in line with Item #3 of the Department's Rationale.

DHS recommends a 2008 implementation date with a budget neutral formula. In contrast, we propose that you consider as early an implementation date as would be feasible with 2007 legislation for strategic funding increases in behavioral care classifications. Since the dawn of case mix reimbursement in Minnesota, consumers and direct care workers have recognized that nursing home reimbursement does not adequately capture the staffing needs and resource use necessary for quality behavioral care.

We now have the verification of the Department's contracted Staff Time Measurement study that, on the whole, behavioral care classes are insufficiently weighted in comparison with complex clinical conditions. During that study, data further indicated that over 60% of residents were found to have moderate to very severe cognitive impairment. We can safely project that with the accelerating use of home and community based services for dementia care, the percentage of nursing home residents with behavioral conditions will increase in the coming years.

Item #3 of the rationale for the DHS budget neutral recommendation suggests that, instead, new funding could accompany the implementation of new case mix weights with a specific policy goal. On that point, we fully agree. We therefore recommend that the Department prepare, for inclusion in the Governor's next biennial budget proposal, a change that directs strategically increased reimbursement for the behavioral care classes, with the goals of improving care quality and staffing for this central and challenging category of care. We thank you and are prepared to cooperate.

Sincerely,

Iris C. Freeman
on behalf of the Coalition

APPENDIX B

COMPARISON OF THE CURRENT AND NEWLY DEVELOPED INDICES

(Page 75 of the report: Development of Case Mix Indices from the Minnesota Nursing Home Staff Time Measurement Study, Prepared for the Minnesota Department of Human Services, By the University of Minnesota, Myers & Stauffer LC and the University of Missouri at Kansas City, October 2005)

Table 8.8 Comparison of Current and New CMIs (Closest MDS or RCU)

RUG-III Groups		Current CMIs	New CMIs	Difference (New - Current)
SE3	Not Used	2.02	1.605	-0.415
SE2	Not Used	1.71	1.247	-0.463
SE1	Not Used	1.51	1.081	-0.429
RAD	17 - 18	1.62	1.509	-0.111
RAC	14 - 16	1.28	1.259	-0.021
RAB	10 - 13	1.20	1.109	-0.091
RAA	4 - 9	1.04	0.957	-0.083
SSC	17 - 18	1.40	1.453	0.053
SSB	15 - 16	1.32	1.224	-0.096
SSA	7 - 14	1.23	1.047	-0.183
CC2	17 - 18 D	1.49	1.292	-0.198
CC1	17 - 18	1.25	1.200	-0.050
CB2	12 - 16 D	1.14	1.086	-0.054
CB1	12 - 16	1.04	1.017	-0.023
CA2	4 - 11 D	1.04	0.908	-0.132
CA1	4 - 11	0.92	0.834	-0.086
IB2	6 - 10 NR	0.85	0.877	0.027
IB1	6 - 10	0.74	0.817	0.077
IA2	4 - 5 NR	0.69	0.720	0.030
IA1	6 - 10	0.53	0.676	0.146
BB2	6 - 10 NR	0.73	0.956	0.226
BB1	6 - 10	0.69	0.885	0.195
BA2	4 - 5 NR	0.61	0.716	0.106
BA1	4 - 5	0.59	0.673	0.083
PE2	16 - 18 NR	1.00	1.199	0.199
PE1	16 - 18	0.98	1.104	0.124
PD2	11 - 15 NR	0.85	1.023	0.173
PD1	11 - 15	0.84	0.948	0.108
PC2	9 - 10 NR	0.84	0.926	0.086
PC1	9 - 10	0.84	0.860	0.020
PB2	6 - 8 NR	0.63	0.786	0.156
PB1	6 - 8	0.63	0.734	0.104
PA2	4 - 5 NR	0.60	0.691	0.091
PA1	4 - 5	0.59	0.651	0.061
Mean for All Groups		1.000	1.000	0.000